Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on December 7, 2005 and 8:00 a.m. on December 8, 2005
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Tim B. Hunter, M.D., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Ronnie R. Cox, Ph.D.
Robert P. Goldfarb, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin Sr., M.D.

WEDNESDAY, December 7, 2005

CALL TO ORDER
Tim B. Hunter, M.D. called the meeting to order at 9:30 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D.

CALL TO THE PUBLIC
Statements issued during the Call to the Public appear beneath the case referenced.

Executive Director's Report
Mr. Miller followed up on the Board's discussion from the October 6-7, 2005 meeting regarding the qualifications of foreign medical schools. He proposed the Board not take this matter to Legislature this year, but rather do a study this year to see how this problem affects Arizona as opposed to the rest of the country and to present any proposal to Legislature by next year.

Ram R. Krishna, M.D. said he is currently on a committee with the Federation of State Medical Boards (FSMB) that is looking into the qualifications of foreign medical schools. The FSMB will have an agency that will be a clearinghouse for the applicants who are foreign graduates. The clearinghouse service will be available for use by all state boards nationwide and so he does not feel the Arizona Medical Board needs to do a study on this issue.

Mr. Miller also highlighted recent updates with Legislation. He said he will be proposing language for the Office Based Surgery Statutes relating to sedation, as requested by the Board, but would also like to add to his proposed language that it be effective immediately. He said that without immediate effectiveness he would have to wait until August 2006 before he could not submit the Office based surgery rules to the Secretary of State because he cannot submit the Rules while they are inconsistent with the Statutes.

Mr. Miller also notified the Board of another current issue. He said the lay midwives are going through their Sunrise review this year and are asking permission to prescribe certain medications during delivery.

Mr. Miller also recognized Arizona Medical Board Senior Medical Investigator, Ms. Pearl Reed, for her 20 years of service with the State of Arizona and for her 20 years of Service to the Arizona Medical Board. The Board presented Ms. Reed with a plaque from the Governor of Arizona and Mr. Miller presented Ms. Reed with a plaque from the Arizona Medical Board.

Request for IT Appropriations

Mr. Timothy Miller, J.D., Executive Director, spoke about obtaining a new database for the agency. He said the current budget does not allow for the purchase of the new database and additional funds would need to be requested. Mr. Miller said the new database would be the only way to allow for on-line renewals. Mr. Miller said he has spoken to ArMA about this possibility and they are in favor of supporting a one time appropriation if the Board agrees that fees will not be raised.

Patrick N. Connell, M.D. noted that the new database would be very extensive and wondered if there were other 90/10 agencies who could benefit from the same system and purchase, while still remaining independent from the Medical Board. Mr. Miller said he is currently discussing this option with another State agency and that it will be necessary that the investigations procedures, licensing procedures and renewal processes are conducted rather similarly so that the system could be compatible with other Boards.

Auditor General Report

Mr. Miller reported to the Board that the agency's Staff has been making extreme progress in processing both new complaints and processing the Agency's backlog. He said the following results have been provided to both the Auditor General's Office and Senator Allen's Office: On January 1, 2005 the Agency's caseload consisted of 65% backlog cases that were received from the years 2002 through 2004. To date, only 8% of the open caseload is cases received prior to 2005. Additionally, Staff has reduced the January 1, 2005 caseload of 1,720 cases to a total of only 950 open investigations to date. Mr. Miller also commented on the tremendous amount of work done by the Staff during the month of November. Staff completed 183 investigations from November 7, 2005 through November 30, 2005. Mr. Miller noted these accomplishments did not sacrifice quality and all cases were thoroughly investigated.

Mr. Miller also commented on the positive culture of the agency and the fact that Staff turnover is no longer an issue. Mr. Miller said that the state's average for agency turnover is between 14%-17% and that the Arizona Medical Board is now well below the average for Staff turnover. Mr. Miller said he has been able to provide both Senator Allen's office and the Auditor General's Office with tangible results of the increasing level of Agency Staff and Staff's commitment to the Agency, which has rectified prior perceptions that the Agency is not stable.

Mr. Miller also provided a report that listed the Arizona Medical Board's statistics for adjudication in complaints that came to the Board by way of mandatory reported malpractice cases. The report showed evidence that the Board does a fair and thorough independent investigation on each malpractice case.

Legal Advisor Report

List of Misdemeanors Reportable Per A.R.S § 32-3208

The Board discussed the requirement that physicians report to the Board criminal charges of misdemeanors that may affect patient safety. The Board was presented with a list of misdemeanors prepared by the Attorney General's Office that Board Staff had been using as a guide. The Board was asked if it wished to use the list as presented or if it wished to make any changes. The Board approved the use of the list as presented. The list will be available on the Board's website and upon request.

Discussion of Process for Election of Board Officers

The Board Members discussed holding a three day Board Meeting on February 8-10, 2006. The Board established a quorum for the three days and asked that election of Board Officers be scheduled as time specific on the second day of the Meeting Agenda. The Board determined they would hold elections for officers in February of every year.

Approval of Minutes

September 23, 2005 Off Site Planning Meeting
September 28, 2005 Summary Action Teleconference Meeting, including Executive Session
October 6-7, 2005 Regular Session Meeting, including Executive Session
October 7, 2005 Summary Action Meeting
October 17, 2005 Summary Action Meeting

Patrick N. Connell, M.D. clarified an amendment that needed to be made to the September 23, 2005 Off Site Planning Meeting Minutes, on page five, item five. Dr. Connell said he the Minutes should be amended to reflect that he asked Staff to look into the feasibility of getting language for the Board to be able to adjudicate cases with false witness testimony. The error reflected Dr. Connell instructed the Staff to go forward with drafting statutory language.

MOTION: Tim B. Hunter, M.D. moved to approve the September 23, 2005 Off Site Planning Meeting as amended, the September 28, 2005 Summary Action Teleconference Meeting, including Executive Session, the October 6-7, 2005 Regular Session Meeting, including Executive Session, the October 7, 2005 Summary Action Meeting, and the October 17, 2005 Summary Action Meeting as amended.
SECONDED: Dona Pardo, R.N., Ph.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-1364A	H.H.	MAVIS J. DONNELLY, M.D.	14026	Advisory Letter for failure to properly manage medication

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					side effects.
2.	MD-04-1497A	AMB	CHARLES H. TADLOCK, M.D.	26067	Advisory Letter for improper supervision of physician assistants

3.	MD-05-0689A	AMB	STANFORD C. LEE, M.D.	30685	Invite the physician for a Formal Interview.

Dona Pardo, R.N., Ph.D. pulled the case for discussion.

Tim B. Hunter, M.D. said in general when a physician prescribes for a family member the Board has issued disciplinary action.

Christine Cassetta, Legal Counsel said she had researched similar cases brought before the Board and could not find record of disciplinary orders issued when there was an isolated incident of prescribing to a family member. Ms. Cassetta did note that it was possible there were consent agreements in such cases.

Dr. Hunter noted the prescribing had appeared to take place over a long period of time and said he would like to interview the physician about the case.

Dr. Pardo inquired about the allegation that the physician was prescribing without an Arizona Drug Enforcement Agency (DEA) number. Maricarmen Martinez, Senior Medical Investigator said the allegation is not sustained because the DEA is a federal agency and does not require a separate license for the State of Arizona. She noted Dr. Stanford Lee does have a federal DEA number.

MOTION: Douglas D. Lee, M.D. moved to invite the physician for a formal interview.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-1464A	R.S.	ANTHONY A. NAZAROFF, M.D.	27092	Dismissed

Robert P. Goldfarb, M.D. knows Mr. Gaines but it will not affect his ability to adjudicate the case.

Anthony A. Nazaroff, M.D. was present with counsel Mr. Ed Gaines and spoke during the call to the public. Mr. Gaines said although the Outside Medical Consultant found the physician did not make known the treatment options to the patient, the medical record documents Dr. Nazaroff spoke to the patient for 35 minutes regarding surgical and non-surgical treatment options. Mr. Gaines feels the Outside Medical Consultant may not have had those particular medical records available. Dr. Nazaroff then reiterated his attorney's statement that he did discuss the treatment options with the patient.

Robert P. Goldfarb, M.D. noted the medical record showing Dr. Nazaroff did appropriately explain the surgical and non-surgical options to the patient had apparently been overlooked.

MOTION: Lorraine Mackstaller, M.D. moved to Dismiss the case.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-04-1421A	P.P.	WAYNE E. BECK, M.D.	9484	Advisory Letter for failure to perform a breast exam.

Patient P.P. and her friend Q.C. were present. Q.C. spoke during the Call to the Public. Q.C. said she was present during Dr. Beck's exam of P.P. and he seemed unconcerned with P.P.'s care and did not notify the patient that a lump existed in her breast in 1998. Because she was not notified of the lump, no follow up appointment was scheduled. The lump was later found by another physician and was cancerous.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-04-0919A	J.B.	THEODORE J. TARBY, M.D.	14187	Advisory Letter for prescribing alcohol to a minor.

Theodore Tarby, M.D. was present without counsel and spoke during the Call to the Public. He said he did recommend small doses of wine for a minor, but it was to treat acidosis. He said there is no other treatment for acidosis and wine can be effective. He said he did not prescribe anything, but simply suggested wine as an alternative treatment.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-04-0697A	F.A.	MARK A. BENSON, M.D.	19371	Advisory Letter for failure to follow-up on an abnormal CT Scan.
8.	MD-04-0939A	S.H.	JOHN. V. WOELLNER, M.D.	12440	Dismissed

Robert P. Goldfarb, M.D. pulled the case for discussion. Dr. Goldfarb commented Dr. Woellner admitted a fee was inappropriately billed for his services, but he offered to refund the money to the patient. Dr. Goldfarb also noted that Dr. Woellner said he had a contract with a major corporation and did not have jurisdiction over the billing process. Further, Dr. Woellner had no incentive to over-bill because he did not profit from the inappropriate billing since he was on an hourly fee with the hospital.

MOTION: Robert P. Goldfarb, M.D. moved to Dismiss the case.
SECONDED: Dona Pardo, R.N., Ph.D.

Paul M. Petelin, M.D. spoke against the dismissal because he said more physicians are becoming employees of facilities and he feels more of these cases will present in the future. Dr. Petelin said that in big corporations a signature stamp is often given to the billing department on behalf of the physician. However, he said he believes this should not relieve physicians of accountability for how their signatures are used.

Dr. Goldfarb said he agreed with Dr. Petelin's remarks, but because this is a one time issue for Dr. Woellner the possibility for error must be considered as it can happen even when the correct code is marked for a service.

Douglas D. Lee, M.D. spoke in favor of the motion because he said that even Medicare requires a pattern to issue a discipline and the Board had no prior pattern of inappropriate billing from Dr. Woellner.

Sharon B. Megdal, Ph.D. noted the Board would have no recorded pattern for this case if they voted to dismiss it.

Douglas D. Lee, M.D. said he believes the physician most likely realizes the severity of this case on the basis that it was recommended to the Board as an Advisory Letter and most likely will watch for this type of thing in the future.

Dr. Hunter said there are thousands of physicians who may not know the mistakes medical billers make. He said that taking action in this case would open the door to hundreds of other cases relating to physicians who work for corporations and have nothing to do with the billing.

VOTE: 6-yay, 5-nay, 1-abstain 0-recuse, 0-absent
Motion passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-04-1428A	B.R.	DONALD E. PAXTON, M.D.	11356	Advisory Letter for failure to independently evaluate CT results.

Paul M. Petelin, M.D. recused himself from the case.

Patient B.R. was present and spoke during the call to the Public. B.R. said that since filing the complaint for her deceased father, she has witnessed a standard of care in her own treatment where a team of physicians work together to update each other with any change in her health status. She said this was not done for her father. B.R. said Dr. Paxton did not inform other physicians of her father's cancer although Dr. Paxton knew well in advance of the disease her father had. B.R. said because Dr. Paxton did not inform her father of his illness, her father was not given the opportunity to see specialists. She said although it is unknown if any course of treatment would have changed the final outcome for her father, but it is certain that her father's trust was violated by this physician who did not allow him to live his final months to in the way he would have chosen.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-04-0173A	AMB	SHAHID P. MALIK, M.D.	31690	Invite the physician for a Formal Interview.

Dona Pardo, R.N., Ph.D. pulled this case for discussion and noted the physician prescribed to his wife for six months.

MOTION: Dona Pardo, R.N., Ph.D. moved to invite the physician for a Formal Interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-03-0147A	E.A.	RONALD D. GORDON, M.D.	8503	Dismissed

Robert P. Goldfarb, M.D. pulled this case for discussion. Brenda Heverly, Senior Medical Investigator looked at billing issues brought up by the medical consultant and found the patient was not covered by the insurance plan and was aware of this fact. Ms. Heverly said the patient elected to pay for her medical fees for a two year period. Ms. Heverly said she did not find any statutory violation.

Stephen Wolf, Assistant Attorney General noted the physician had a thorough consent signed by the patient that listed the varicose veins could reoccur.

MOTION: Ram R. Krishna, M.D. moved to Dismiss the case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 3-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-05-0115A	J.M.	RONALD B. JOSEPH, M.D.	8699	Dismissed

William R. Martin, III, M.D. recused himself from the case.

The patient's wife A.M. was present and spoke during the call to the Public. She said her husband could not be present due to health reasons. She said she has researched and sought opinions from other professionals and feels Dr. Joseph performed below the standard of care. She said Dr. Joseph performed surgeries with the full knowledge that her husband had been having seizures. She said they were never informed of the risks of the procedures and were not provided with an informed consent form. She also said Dr. Joseph prescribed inappropriately for her husband and wrote unfounded slanderous remarks in his medical record.

Dona Pardo, R.N., Ph.D. pulled this case for discussion.

Gerald Moczynski, Medical Consultant summarized the case to the Board. He said he was only able to substantiate the allegation that the medication prescribed was contraindicated.

Dr. Pardo noted that the physician had received previous Advisory Letters. Dr. Hunter said that although the physician has prior Board history, there was nothing inappropriate found in this case.

MOTION: Dona Pardo, R.N., Ph.D. moved to Dismiss the case.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-05-0125A	C.S.	PHILIP G. GLENNIE, M.D.	23555	Advisory Letter for disclosing privileged information.
14.	MD-05-0120A	J.S.	MARC E. GOTTLIEB, M.D.	20039	Advisory Letter for inadequate medical records for preparing an untimely operative report.

Paul M. Petelin, M.D. recused himself from the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-02-0828A	AMB	JAMES F. BLUTE III, M.D.	6998	Invite the physician for a Formal Interview.

Robert P. Goldfarb, M.D. recused himself from the case.

Patrick N. Connell, M.D. commented that Arizona Medical Board Staff found Dr. Blute was not forthright with the investigation in that he made misleading statements regarding the availability of his treatment records and his post-operative involvement with the patient's care.

Ingrid Haas, M.D., Medical Consultant summarized the case. Dr. Blute was initially noticed for negligent surgery and failure to follow up on post-op complications. He was then renoticed on poor medical records. After an interview with Staff it was noted that his medical records and testimony conflicted each other and Dr. Blute was noticed on false information provided to the Board.

MOTION: Paul M. Petelin, M.D. moved to invite the physician for a Formal Interview.
SECONDED: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain 1-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-04-0426A	J.E.	ZALALEM YILMA, M.D.	25431	Dismissed

Dr. Zalalem Yilma was present with counsel Mr. Steve Myers, and spoke during the call to the public. Mr. Myers asked the Board to reconsider the case and dismiss the matter. Mr. Myers said he felt there was a discrepancy between the two Medical Consultants who reviewed the case. He said the consultant the Board hired was not qualified for the case and relied largely on the ACC/AHA Guidelines. Mr. Myers said the reviewer he hired found the ACC/AHA guidelines are only guidelines and Yilma did not deviate from the standard of care.

Lorraine Mackstaller, M.D. said the patient alleged Dr. Yilma evaluated her for symptoms unrelated to her visit. Dr. Mackstaller noted, however, the patient presented with symptoms of cardiovascular manifestations and Dr. Yilma's care was appropriate. She said the patient had cardiovascular risk in her family history and that the patient was later found to have an obstruction. Dr. Mackstaller said she feels this data supports Dr. Yilma's evaluation.

MOTION: Lorraine Mackstaller, M.D. moved to Dismiss the case.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-04-1273A	K.B.	FRANCIS K. TINDALL, M.D.	14589	Advisory Letter for inappropriate up-coding of billing.
18.	MD-05-0034A	C.K.	ROBERT H. WOODS, M.D.	22242	Advisory Letter for excessive billing.
19.	MD-05-0201A	A.M.	JEFFREY S. MALTZMAN, M.D.	30438	Dismissed

Jeffrey Maltzman, M.D. was present without counsel and spoke during the Call to the Public. He said he felt the patient's symptoms were consistent with cataracts. He later diagnosed the patient with keratoconus. He noted that some cases are more subtle than others and that the patient did not present with the usual signs for keratoconus. Dr. Maltzman said the patient had good results with his care ultimately. He

said in hindsight, he can see this case clearly, however, he still feels this diagnosis would have been hard to determine initially and has since become more cautious.

MOTION: Lorraine Mackstaller, M.D. moved to Dismiss the case.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-05-0027A	AMB	MICHAEL MAHL, M.D.	12868	Offer a Consent Agreement for a Letter of Reprimand for attempting to prescribe medications in violation of his Board Order. If he does not accept the consent agreement, invite the physician for a formal interview.

Sharon B. Megdal, Ph.D. recused herself from the case.

Kathleen Muller, Senior Compliance Office summarized the case. On August 9, 2002 Dr. Mahl entered into a Consent Agreement and Order for Practice Restriction with Probation. On December 20, 2004 Board Staff received a call from Michel Sucher, M.D., Board Addictionologist stating Dr. Mahl was suspended from his employment for authorizing new prescriptions for himself, in violation of his Consent Agreement. Although the prescriptions were authorized by Dr. Mahl, the authorization was intercepted by Dr. Mahl's employer and the prescriptions were was not filled.

Tim B. Hunter, M.D. noted the physician was under the MAP Program at the time of the attempted self-prescribing, but could have otherwise written the prescription since it was a non-controlled substance.

Michel Sucher, M.D., Board Addictionologist said Dr. Mahl did not initially realize self-prescribing was an issue, but after a recent meeting with Dr. Sucher he has come to understand the gravity of his error. Dr. Sucher said the physician has since gotten back on track and is fully compliant with the terms of his MAP agreement.

Dona Pardo, R.N., Ph.D. said the physician violated his Board Order and the Board disciplines for Board violations. Dr. Pardo said she would like to stay consistent with previous Board actions.

MOTION: Ram R. Krishna, M.D. moved to offer a Consent Agreement for a Letter of Reprimand for attempting to prescribe diabetic medications in violation of his Board Order. If he does not accept the consent agreement, invite the physician for a formal interview.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 9-yay, 1-nay, 0-abstain 1-recuse, 1-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-05-0079A	K.S.	ELEANOR A. CLARK, M.D.	16389	Advisory Letter for failure to properly evaluate liver enzymes.
22.	MD-03-1058A	A.N.	TERRY R. MAXON, M.D.	4717	Advisory Letter for inappropriately leaving the operating room with a syringe containing Versed.

MOTION: Robert P. Goldfarb, M.D. moved to issue Advisory Letters for items 1,2,5,6,7,9,13,14,17,18, 21 and 22.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 1-abstain 0-recuse, 0-absent
Motion Passed.

APPEAL OF ED DISMISSAL

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0141A	R.S.	MARK L. SHWER, M.D.	11957	Uphold Executive Director's Dismissal

Attorney Scott Ambrose and Senator Karen Johnson were present with patient R.S. and addressed the Board during the Call to the Public. Mr. Ambrose said the patient was not aware she was pregnant at the time she took Amphetamines for a cold. She later had a urine test that was positive for Amphetamines. The baby was born prematurely and, because of the positive Amphetamines test, CPS got involved.

Mr. Ambrose stated the medical records on patient R.S. were clearly inaccurate. He had written she was positive for Methamphetamines and Amphetamines, was homeless, was living from a car, was abused, and her husband was in jail. Mr. Ambrose said that all of these accusations were not even remotely correct. He said that because of Dr. Mark Shwer and Dr. Robert Gutierrez's records, CPS took R.S's child away from her for nine months.

Patient R.S. said she sent three certified mail cards to Dr. Shwer and Dr. Gutierrez asking them to change their medical records. She said she did not receive the courtesy of a response from the two physicians. Meanwhile, while her child was in foster care, CPS told her they had reliable confidential medical records with which they were basing their case. To date, she said her son's medical records still reflect inaccurate information about the false allegations for the CPS case.

Senator Karen Johnson spoke in support of patient R.S. She said she has been working with R.S. over the past year and has found her to be a responsible individual and very thorough in gathering information.

Attorney Mary Pryor, was present and spoke on behalf of Dr. Shwer. She said she found nothing in the medical chart that showed the test result was reported as positive for Methamphetamines. She said the lab result is also part of the medical record and would show the correct result even if there was an error in the chart. Ms. Pryor said it would not have been acceptable for Dr. Shwer and Dr. Gutierrez to change the medical records because they did not personally collect the information on the patient, but rather had it given to them by other physicians.

Douglas D. Lee, M.D. said he did not believe the accusations were sustainable. He said the physicians must refer information to CPS for a positive Amphetamine test or else they are in violation of statute. Dr. Lee said he does not see that Dr. Shwer and Dr. Gutierrez's records were directly related to CPS taking the child because their information was gathered from several sources.

William R. Martin, III, M.D. and Paul M. Petelin, M.D. said they believed the physicians had an obligation to respond to a patient in relation to their personal medical record.

Dona Pardo, R.N., Ph.D. commented that the social worker and another physician's report were much more damaging to the patient than Dr. Shwer and Dr. Gutierrez's records were.

Lorraine Mackstaller, M.D. said it appeared R.S.'s case was largely against C.P.S. rather than against Dr. Shwer and Dr. Gutierrez.

MOTION: Douglas D. Lee, M.D. moved to uphold the Executive Director's Dismissal for both cases.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0141B	R.S.	ROBERT V. GUTIERREZ, M.D.	27698	Uphold Executive Director's Dismissal

Refer to the Minutes for case above under Mark L. Shwer, M.D., MD-04-0141A

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0359A	S.B.	SANFORD H. ROTH, M.D.	4427	Uphold Executive Director's Dismissal
4.	MD-04-1147A	V.K.	ROBERT V. STEPHENS, M.D.	7356	Uphold Executive Director's Dismissal
5.	MD-03-0754A	A.E.	PATRICIA LEBENSOHN, M.D.	21694	Uphold Executive Director's Dismissal
6.	MD-04-1436A	M.A.	LLOYD P. CHAMPAGNE, M.D.	27791	Uphold Executive Director's Dismissal

Robert P. Goldfarb, M.D. said he knows Mr. Robert Milligan but will not hinder his ability to adjudicate the case.

William R. Martin, III, M.D. said he knows Dr. Champagne and recused himself from the case.

Patient M.A. was present and spoke during the Call to the Public. The patient presented to Dr. Champagne with a broken finger. During her care she was told by the office they would no longer be accepting her insurance plan in general, but would continue to treat after her insurance changed. During the course of her care, M.A. said the office failed to honor their word and told her she had to provide a $3,000 money order before they would continue her treatment. M.A. said she currently has a shunt in her finger and believes her finger may now be permanently deformed. She said no other physician is willing to assume care for her.

Dr. Champagne was present with legal counsel, Mr. Robert Milligan, and spoke during the Call to the Public. Dr. Champagne said he did the patient a favor and agreed to operate on her on Christmas Eve, since her insurance was due to expire on January 1st. He said he discussed with the patient the likely possibility of needing a second surgery. Dr. Champagne said by February the fracture wasn't healing and he recommended another surgery. In February he and the patient met to discuss options but she had changed insurances. He said the patient came the next day and prepaid for the procedure because she was no longer on an insurance plan his office could accept. Dr. Champagne said the patient signed an agreement outlining her payment responsibilities and chose to stay with him of her own accord. Several months later the patient wrote the office stating she felt a refund was necessary. However, Dr. Champagne felt the data did not support her request for a refund.

Mr. Milligan said the chart shows the patient was non-compliant with physical therapy and declined a surgery at one point because she said it was a busy time of the year. He said that any deformity in her finger may have been because of non-compliance with the physician's orders. Mr. Milligan also noted it would be insurance fraud if Dr. Champagne had written the patient's charges off.

MOTION: Sharon B. Megdal, Ph.D. moved to uphold the Executive Director's Dismissal.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 1-recuse, 0-absent
Motion Passed.

MOTION: Robert P. Goldfarb, M.D. moved to uphold the Executive Director's Dismissal of items 3, 4, and 5.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-03-0970A	J.D.	JOHN M. RITLAND, M.D.	17268	Refer case to Formal Hearing.

This case was pulled for discussion.

Douglas D. Lee, M.D. recused himself from the case.

Christine Cassetta, Legal Counsel summarized that this case had been referred to Formal Hearing by the Executive Director, but an appeal was filed by Dr. Ritland because he felt part of what had been referred to Formal Hearing, he had never been noticed on nor responded to and he was correct. The Executive Director rescinded his referral, allowed the physician time to respond and has now returned the case to the Board for referral to Formal Hearing.

MOTION: Ram R. Krishna, M.D. moved to refer the case to Formal Hearing.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain 1-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0668A	AMB	WESLEY JOHNSON, M.D.	26379	Uphold Executive Director's Dismissal.

MOTION: Ram R. Krishna, M.D. to accept the Executive Director's Dismissal.
SECONDED: Becky Jordan
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-0932A	S.H.	MICHAEL EPNER, M.D.	24722	Accept the Consent Agreement for a Decree of Censure and Civil Penalty for $5,000.00 for failure to maintain adequate medical records.
5.	MD-04-1032A	AMB	JUSTIN WEISS, M.D.	9418	Accept the Consent Agreement for a Letter of Reprimand for failure to correctly read an x-ray.

Tim B. Hunter, M.D. recused himself from the case.
Robert P. Goldfarb, M.D. recused himself from the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-04-0588A	AMB	JACK O. MCFARLAND, M.D.	3831	Accept the Consent Agreement for a Letter of Reprimand for performing a clean site surgery in combination with a contaminated site surgery.

MOTION: Ram R. Krishna, M.D. moved to accept the Proposed Consent Agreements for items 4, 5, and 6.
SECONDED: Robert P. Goldfarb, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-0666A	R.S.	JOHN W. MCGETTIGAN, M.D.	12606	Deny Motion for Rehearing.

Dean Brekke, Assistant Attorney General filed a motion for denial of rehearing. He said there is evidence in the record that would support findings that Dr. McGettigan did obtain a fee for false advertising.

MOTION: Ram R. Krishna, M.D. moved to deny the motion for rehearing.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-03-0437A	AMB	ANCA M. MARAS, M.D.	13103	Deny the motion for rehearing.

Stephen Wolf, Assistant Attorney General presented the case to the Board. Mr. Wolf noted nothing in Dr. Maras motion should cause the Board to grant her a rehearing. Mr. Wolf went on to note Dr. Maras had failed her PACE evaluation. He said there is ample aggravating evidence that Dr. Maras is medically incompetent.

Douglas D. Lee, M.D. said he felt the Board had taken sufficient action to protect the public through the previously drafted order that required Dr. Maras to practice under a supervising physician.

MOTION: Douglas D. Lee, M.D. moved to deny the motion for rehearing.

Mr. Wolf said he did not believe there were any terms for a supervisor in the Order, but the Order rather required Dr. Maras to practice in a group setting.

Sharon B. Megdal, Ph.D. said there was peer review that said Dr. Maras was able to practice anesthesia safely. Dona Pardo, R.N., Ph.D. noted the peer review was based solely on Dr. Mara's knowledge base. Sharon B. Megdal, Ph.D. said it is concerning that the physician does not acknowledge her lack of judgment.

Paul M. Petelin, M.D. voiced his concern that he believes Dr. Maras is a danger to the public.

SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-04-0739A	AMB	SCOTT A. WASSERMAN, M.D.	23328	Accept the Findings of Fact, Conclusions of Law for a Letter of Reprimand for falsely advertising an employee as a licensed physician and/or aesthetician.
11.	MD-04-0859A	AMB	ROY R. GETTEL, M.D.	11015	Accept the Findings of Fact, Conclusions of Law for Probation and Decree of Censure for negligently performing open reduction and internal fixation of an ankle resulting in malposition.

Robert P. Goldfarb, M.D. abstained from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-03-1280A	T.H.	MARVIN L. GIBBS, M.D.	13736	Accept the Findings of Fact, Conclusions of Law for a Letter of Reprimand for providing false information on an application for hospital privileges and for failure to maintain adequate records on a patient.
13.	MD-04-1399A	AMB	JEROLD D. WHITE, M.D.	5146	Accept the Findings of Fact, Conclusions of Law for a Letter of Reprimand for prescribing controlled substances to a member of his immediate family.
14.	MD-04-0977A	B.P.	CRAIG A. BITTNER, M.D.	27982	Accept the Findings of Fact, Conclusions of Law for Probation and Restitution in the amount of $3,810.00 to patient B.P. The Probation will terminate when the Board receives satisfactory proof that the restitution has been made.
15.	MD-04-0236A	C.R.	KENNETH M. FISHER, M.D.	12762	Accept the Findings of Fact, Conclusions of Law for a Letter of Reprimand for inappropriate diagnosis and treatment of a skin lesion and for failure to maintain adequate records.
16.	MD-03-1019A	M.D.	HELEN WATT, M.D.	22016	Accept the Findings of Fact, Conclusions of Law for a Letter of Reprimand and Probation for inappropriate treatment of an abdominoplasty wound; inappropriate treatment of burns; and failure to maintain adequate medical records.

Helen Watt, M.D. was present without legal counsel and spoke during the call to the public. She said there were a couple of proposed amendments to the Board Order she wished the Board to consider. Dr. Watt said she would not be able to attend the PACE course until July because of the PACE scheduling and because of the financial burden. She asked the Board to grant an extension to complete the PACE course. Alternatively, she asked the Board to consider the possibility of her taking a record keeping course through MICA.

Christine Cassetta, Legal Counsel noted that she reviewed Dr. Watt's written objections to the Order and confirmed that the Order was correct by reviewing the transcript. She also noted there were two changes requested by counsel that were not directly related to transcript testimony that the Board may consider. Ms. Cassetta also noted that by the time the Order is finalized, July may be a reasonable time frame to attend PACE in order to comply with the time frame stipulated in the Order. Ms. Cassetta also noted that if PACE cannot accommodate a physician within the time-frame of the Order Board Staff works with the physician to get them into PACE at the first available opportunity and the physician is not deemed in violation of the Board Order if PACE cannot accommodate her.

MOTION: Douglas D. Lee, M.D. moved to accept the Order as written.
SECONDED: William R. Martin, III, M.D.
VOTE: 10-yay, 0-nay, 1-abstain 0-recuse, 1-absent

Motion passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-04-0018A	C.S.	DAVID D. PARRISH, M.D.	26896	Findings of Fact, Conclusions of Law for a Letter of Reprimand, Suspension and Probation for misdiagnosis and mismanagement of thyroid disease.
18.	MD-05-0054A	AMB	GERALD TELEP, M.D.	12749	Invite the physician for a Formal Interview.

Kathleen Muller, Senior Compliance Officer summarized the case. On October 19, 1996 Dr. Gerald Telep entered into an indefinite confidential Stipulated Rehabilitation Agreement. During the term of his Agreement, he has been a participant in the Medical Board of California's confidential Diversion Program. The bi-annual reports of compliance have been sent to the Arizona Medical Board from California.

Upon review of the April 2004 report, it was noticed that Dr. Telep apparently suffered a relapse. Dr. Telep admitted he did relapse with the use of alcohol and completed a relapse prevention program and signed a continuation contract with the California Diversion Program for an additional three years. Subsequent reports from the California Diversion Program have all been favorable.

Michel Sucher, M.D., Board Addictionologist said Dr. Telep is in the California diversion program for three more years and would like to see Dr. Telep monitored by Arizona for the remainder of those three years.

MOTION: Sharon B. Megdal, Ph.D. moved to invite the physician for a Formal Interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-98-0006 MD-99-0096 MD-99-0543 MD-00-0801	AMB	JOHN V. DOMMISSE, M.D.	22164	Issue an Amended Order with the changes Ordered by Superior Court as presented in the State's motion.

Mr. Kraig Marton, legal counsel for Dr. Dommisse was present and spoke on behalf of Dr. Dommisse who was not present.

Mr. Brekke summarized the case stating the Superior Court ordered changes to the Findings in the Board's Order and also ordered the Board to dismiss case MD-00-0801. The court upheld the other actions by the Board.

Mr. Marton asked this matter be re-considered by the Board with application of today's standard of care, which Dr. Dommisse complied with. Mr. Marton said not all evidence was presented to the Board the first time and Dr. Dommisse feels this case was not fairly judged. Mr. Marton said there is an evolving standard of care and, although the Board may have found Dr. Dommisse to be below the Standard of Care when they initially judged the case, they may now find his treatment was acceptable.

Sharon B. Megdal, Ph.D. said it would be easier to view the case if the materials were presented to the Board in a manner in which the Order showed the proposed additions in red and the proposed deletions struck through. Christine Cassetta, Legal Counsel said the main changes ordered by the Superior Court were to remove certain findings the Court found were not sustainable (as presented by Mr. Brekke).

William R. Martin, III, M.D. spoke against the motion because the case has been decided by the Superior Judge and it is clear what needs to be done.

MOTION: William R. Martin, III, M.D. moved to issue an Amended Order with the changes Ordered by Superior Court as presented in the State's motion.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. The following Board Member abstained: Paul M. Petelin, M.D.
VOTE: 11-yay, 0-nay, 1-abstain 0-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-05-1018A MD-05-0013A MD-05-0605A MD-05-0681A	AMB	SUDHIR K. GOEL, M.D.	27103	Accept the Interim Consent Agreement for Practice Restriction.

Paul M. Petelin, M.D. recused himself from the case.
Sharon B. Megdal, Ph.D. abstained from the vote on this case.

MOTION: Patrick N. Connell, M.D. moved to accept the Interim Consent Agreement for Practice Restriction.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 1-abstain 1-recuse, 0-absent

Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-05-0884A	AMB	HARSHAD S. PATEL, M.D.	22757	Accept the Interim Consent Agreement for Practice Restriction.

MOTION: Patrick N. Connell, M.D. moved to accept the Interim Consent Agreement for Practice Restriction.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 1-abstain 0-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
22.	MD-05-0206A	AMB	SUSAN VAN DYKE, M.D.	20156	Accept the Consent Agreement for License Reactivation, Stayed Revocation and Probation.

Dr. Susan Van Dyke was present without counsel and spoke during the Call to the Public. Dr. Van Dyke stated she is in recovery and has had a change of life for which she is grateful. She said she is currently fully participating in the MAP program.

Michel Sucher, M.D., Board Addictionologist said he was in favor of the Consent Agreement.

MOTION: Patrick N. Connell, M.D. moved to accept Consent Agreement for License Reactivation, Stayed Revocation and Probation.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
Motion Passed.

MOTION: Ram R. Krishna, M.D., moved to accept the Findings of Fact and Conclusions of Law for items 10,11,12,13,14,15,17.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

WEDNESDAY, DECEMBER 7, 2005

CALL TO ORDER

Tim B. Hunter, M.D. called the meeting to order at 9:30 a.m.

ROLL CALL

The following Board Members were present: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, M.D.

CALL TO PUBLIC

Statements issued during the Call to the Public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-1177A	AMB	RUSSELL BECK, M.D.	17248	Dismissed

Dr. Russell Beck was present without counsel.

Ingrid Haas, M.D., Medical Consultant summarized the case. The case came to the Arizona Medical Board due to a malpractice case that was filed in 2003. The incident occurred in 1990. The claim alleged the improper use of forceps resulted in a deformity of the right forehead of the infant. The mother of the infant had been a patient of Dr. Beck's prenataly. During the labor, Dr. Beck's partner, who was the father of the baby, followed the patient until the second stage of labor. The second stage of labor was approximately two and a half hours in length. Dr. Beck arrived shortly before the delivery. Forceps delivery was elected. It was alleged that there were two failed attempts to apply forceps with the forceps slipping off, but the third attempt was successful. At delivery, injuries of the face and forehead were identified. Secondarily, a fracture of the frontal temporal portion of the skull was identified. Dr. Haas noted the information available to the Board is based on the legal records since hospital records and labor and delivery records are not available since the incident occurred so long ago.

Dr. Haas presented CAT scan films of the child at one and a half years of age. Photographs from the child's reconstructive surgery performed in 2002 were also viewed by the Board at the time of the meeting.

Dr. Beck said he regrets the incident and injuries to the child and the pain of the family. Dr. Beck testified there were bilateral forceps marks on the baby that shows the forceps were correctly positioned. He said the injuries occurred in a common area for injuries to occur with forceps. Dr. Beck contended the presence of injury does not prove the forceps were incorrectly placed.

Dr. Beck said the allegation against him claims the child had more than one corrective surgery. However, he said he has never seen any records to indicate more than one surgery was performed on the child. Dr. Beck said the deformity was due to the child's skin atrophying over the years and there was no brain damage.

Dr. Beck said the forceps did not slip off the infant, but rather it is the patient's allegation that a slip occurred. Dr. Beck said he has never had forceps slip off an infant in any delivery. Dr. Beck thought the depression fracture could be because the infant's head did not fit the forceps. He said his pressure to pull the baby did not seem more than any other time, but that he is much gentler in his pull now. Dr. Beck said the incident happened 15 years ago and he has not had a repeat incident. Dr. Beck said it is his practice now that if the baby does not come out easily with the forceps he immediately discontinues the forceps.

Robert P. Goldfarb, M.D. led the questioning and notified Dr. Beck that he was correct in that the record shows the patient had one surgery and not five.

Robert P. Goldfarb, M.D. noted the American Medical Association's position against treating one's own family because of the loss of objectivity. Dr. Beck said the husband was a good friend of his and was his partner. He said the husband did not assist him during the time of the delivery. Dr. Beck testified, however, he would not allow a family member to assist in this way in the future.

Dr. Goldfarb asked Dr. Haas about her findings on the standard of care in this case. Dr. Haas said she agreed the father treating his spouse was questionable, but does not know if it falls below the standard of care. Dr. Haas said the forceps, if applied properly, should not have caused injury.

Ram R. Krishna, M.D. noted Dr. Beck was a couple of years into practice when he performed the patient's delivery.

Douglas Lee, M.D. noted that if there was no mal-application of the forceps, there must have been some slippage for the injury to be above the forceps initial application area.

Robert P. Goldfarb, M.D. asked Dr. Beck why the allegation of the forceps slipping had not been resolved earlier. Dr. Beck said that, although there was litigation, there were never any depositions because the case settled. Dr. Beck said an outside consultant looked at his medical records and thought slippage did not occur.

Dr. Goldfarb asked Dr. Haas about her perception of the forceps slipping. Dr. Haas said the records are not available for her to review, but speaking to the application of the forceps in general, they can be applied properly, but with the improper direction of pull, injury can occur. She said if the physician does not pull through the curve of the pelvis, the forceps can, in a sense, "slip" without slipping entirely off, prohibiting them from grasping the infant's head in the proper position. She also said if the baby's head was not directly down and forceps were applied to a head that was caught slightly, the force of the blades could be on a point that could crush. Dr. Haas concluded there must have been one of these factors present in this case that prevented the procedure from being appropriately carried through.

Dr. Goldfarb said he did not feel the case rose to the level of discipline and noted that no medical records were available to refute the physician's testimony.

Patrick N. Connell, M.D. said he felt the evidence did not support an Advisory Letter.

MOTION: Ram R. Krishna, M.D. moved to Dismiss the case.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D. The following Board Members voted against the motion: Robert P. Goldfarb, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Paul M. Petelin, M.D.
VOTE: 8-yay, 4-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-03-0239A	S.S.	WILLIAM E. MORA, M.D.	13088	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for unbundling codes and billing irregularities. One year Probation for 10 hours Board approved CME in ethics and 10 hours CME in CPT coding and billing issues, in addition to CME required for license renewal. Probation terminates upon completion of CME.

William Mora, M.D. was present with counsel, Mr. Michael Bradford.

Gerald Moczynski, M.D., Medical Consultant presented the case to the Board. This is a complaint that was filed with the Arizona Medical Board on March 11, 2003, by the medical director of the State compensation fund of Arizona. He was concerned with Dr. Mora's repeated

and excessive testing and procedures on a patient that sustained a work injury to his hand. Specifically, he expressed concerns about Dr. Mora's upper extremity muscle testing and head and neck muscle testing prior to anesthesia. He also was concerned about Dr. Mora's billing for repeat upper extremity muscle testing, the use of a pulse oximeter, the use of osteopathic manipulation of the carpal ligament and Dr. Mora's testing of patient's body fat.

The case was reviewed by an outside medical consultant who concluded there should not be separate charge for the muscle testing and that the use of an oximeter in the body fat analysis could not be supported. The Consultant concluded there may be a substantiated allegation of obtaining a fee by fraud, deceit, or misrepresentation.

Dr. Moczynski said he had reviewed the records and that the records document the patient had preoperative head and neck muscle testing, jaw muscle testing and upper extremity muscle testing on six occasions and there was billing for those tests. There were separate upper extremity muscle testings on 20 occasions and bills for those as well. Range of motion measurements were recorded and billed for on 18 occasions. Manipulation of the carpal ligament was billed for on seven occasions. Pulse oximetry in the office was billed for on three occasions, and body fat analysis was billed for on two occasions.

Additionally, the patient underwent a nerve conduction monitoring with dermal electrodes in the office and then had to have those retested by an outside examiner with needle electrodes. The various charges for these procedures by Dr. Mora were in excess of $7,000 depending on how the procedures are interpreted.

William R. Martin, III, M.D. led the questioning. Dr. Mora summarized his training. It was Dr. Mora's testimony that his training during his fellowship taught him was that body mass index testing was an appropriate tool to asses a patient's hand. Dr. Mora said he was also taught that pulse oximetry was the proper practice to evaluate a patient's hand and that he believes his methods are the standard of care in the community, if not in Arizona, then world-wide.

Dr. Mora said he sees 40-60 patient's on a daily basis and the pulse oximetry is only done once or twice a month for patients who have crush injuries. Dr. Mora said the pulse oximetry test is used as a superior to the Allen's test although a small number of patients have been determined to be abnormal from the pulse oximetry test.

Dr. Mora elaborated on his routine check for a patient presenting with a hand problem. William R. Martin, III, M.D. asked why muscle testing was not part of the motor testing for a regular exam and why he billed separately for the test. Dr. Mora said he bills according to the codes available for his services.

Dr. Martin referred to an article Dr. Mora submitted supporting his practice of pulse oximetry. Dr. Martin noted the article was written in 1988 and Dr. Mora was unable to refer to any other articles that supported his practice of pulse oximetry, whether they be peer review journals, medical journals or text books. Dr. Mora said he did not consider textbooks to be authoritative, but to be used only to provide information. Dr. Martin noted that although Dr. Mora said his practice was community standard, he was able to name only one other physician who treated patients in the same way he did.

Ram R. Krishna, M.D. asked how Body Mass Index (BMI) helps Dr. Mora asses a finger. Dr. Mora said it was not the best tool, but that he uses the BMI results to determine if the patient is gaining weight during the time of recovery. Dr. Krishna noted there was no purpose to watch a patient's BMI unless the patient was being treated for obesity. Dr. Krishna also said he believes pulse oximetry is part of a standard evaluation and does not believe it can be billed for separately.

Dr. Krishna questioned Dr. Mora about his immobilization of the patient's finger in the first procedure, and his subsequent surgery and the third procedure in follow up for the patient. He noted no patient harm in this case.

Robert P. Goldfarb, M.D. noted an inappropriate test performed by Dr. Mora that was testified of in a letter Dr. Mora wrote to the state compensation insurance fund. Dr. Mora said the test is referred to as jaw muscle testing and is given before a patient receives general anesthesia to determine if they can open their mouth for the tracheal tube and lift their neck off the operating table. Dr. Mora said he did this type of testing for one anesthesiologist only.

Dr. Goldfarb noted there were random billing records that consistently showed Dr. Mora billed for a detailed examination and then would bill for several a la carte evaluations that should have been included in the detailed examination.

Douglas D. Lee, M.D. noted that since it was Dr. Mora's testimony he used the BMI testing to obtain only to a crude measurement of weight, why not use a scale or a calculator, rather than charging the system for a more complex procedure.

Sharon B. Megdal, Ph.D. asked the Staff if there were any other patient care issues. Maricarmen Martinez, Senior Medical Investigator said there were no other patient records reviewed, but the Medical Consultant found no issue with the actual care of the patient in this case.

In response to an earlier Board inquiry Christine Cassetta, Legal Counsel informed the Board Dr. Mora obtained his initial dispensing application from the Board in 2004. Dr. Krishna noted Dr. Mora dispensed medication without a dispensing license in 2002.

Mr. Bradford, counsel for Dr. Mora, said using separating billing codes for various procedures can be helpful to the insurance company should they find they did not approved of the way the billing was done, they could isolate the bills they would choose not to pay.

Dr. Martin said that although no patient harm was done, he was concerned about the physician's ethics as well as irregularities in his billing. He said he does not know how to encourage the physician to get additional training in those areas without rising to a level of discipline. Dr. Martin said he did not believe it was community standard to follow a patient's vascular status or BMI if relating problems to those results

were not treated. He said he also did not believe it was community standard to conduct jaw muscle testing simply for the use of anesthesia. He further found the physician had fallen below the standard of care by unbundling codes and billing separately.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(v) - Obtaining a fee by fraud, deceit or misrepresentation.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 1-abstain 0-recuse, 0-absent

Sharon B. Megdal, Ph.D. abstained because she felt there had not been thorough evidence to suggest if the billing was or was not a pattern.

Dr. Martin said he believed there were clear ethical lapses on the physician's part and CME was warranted.

MOTION: William R. Martin, III, M.D. moved to issue Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for unbundling codes and billing irregularities. One year Probation for 10 hours Board approved CME in ethics and 10 hours CME in CPT coding and billing issues, in addition to CME required for license renewal. Probation terminates upon completion of CME.
SECONDED: Ronnie R. Cox, Ph.D.

Dr. Martin suggested that staff perform a record review. Dr. Cox said he would appreciate clarity from staff's research to know if Dr. Mora's conduct presents a pattern.

Dr. Krishna asked that the issue of dispensing medications without a license be looked into by the staff.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-1357A	AMB	SAMUEL A. NELSON, M.D.	7590	Advisory Letter for improper management.

Samuel Nelson, M.D. was present with counsel, Mr. Dan Cavett.

Robert P. Goldfarb, M.D. said he knows Mr. Cavett, but it will not affect his ability to adjudicate the case.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. The case was reviewed by an outside consultant who is a psychiatrist. The patient alleged Dr. Nelson inappropriately prescribed to him and at the time of the complaint Dr. Nelson was on probation with the Board.

The case involved an adult with ADHD. The consultant stressed that such patients need a thorough evaluation, including an extensive history going back to childhood and corroborating history from other witnesses, as well as screening for substance abuse and monitoring of vital signs because the usual treatment is stimulant in nature and blood pressure, pulse and EKG's need to be looked at before treatment as well as periodically thereafter. The consultant thought Dr. Nelson deviated by not doing a thorough pretreatment workup and not documenting serial vital signs or laboratory studies. As part of the review, nine other cases of Dr. Nelsons were reviewed and the consultant noted that four of the nine were for Dexedrine, which he felt was an unusually high percentage. Dr. Nelson seemed to start the medication quite readily for patients, usually on the historical information provided by the patient rather than really assessing the disease as recommended by the consultant.

Robert P. Goldfarb, M.D. led the questioning and spoke specifically on the case involving patient J.T. who had cocaine and amphetamine dependence. Dr. Goldfarb stated the medical record showed Dr. Nelson was trying to discontinue the Dexedrine for the patient, but that he continued to prescribe it anyhow. Dr. Nelson said he knew the patient had been a remote user ten years prior to seeing him and that the patient told him he used Amphetamines occasionally, but Dr. Nelson said he did not consider the patient to be a regular user.

Dr. Goldfarb noted it was below the standard of care for Dr. Nelson to prescribe Dexedrine on the basis of verbally listed symptoms without collaboration and to prescribe Dexedrine although the current usage of Amphetamines was reported by the patient.

Dr. Goldfarb asked why there wasn't an EKG in the record. Dr. Nelson said he relied on his patient's verbal history of no hypertension and did not take his blood pressure. He said he currently no longer relies on the patient's story alone.

Tim B. Hunter, M.D. asked how he has since changed his practice. Dr. Nelson said he is now including a template that will include regular monitoring of vital signs for all patients who take vasoactive substances.

Paul M. Petelin, M.D. asked Dr. Nelson about the contraindications of Dexedrine and Amphetimes. Dr. Nelson said stimulant drugs are now used as augmenting agents for antidepressants. He said, however, there are interactions such as with Effexor that can raise blood pressure and in some instances can induce tachycardia.

Mr. Cavett, counsel for Dr. Nelson, said Dr. Nelson has complied with the necessary documentation for handling pain treatment patients. He said that less than 23% of his patients have any type of stimulant drug. He said that additionally, two of every three patients with ADHD had significant questionnaires from relatives, coworkers and friends documenting their observations of behavior. Mr. Cavett also noted Dr. Nelson had no prior violation of Board orders and was released from Probation this past year.

Dr. Goldfarb said he felt there was no patient harm found in this case and improper patient management to some degree.

MOTION: Robert P. Goldfarb, M.D. moved to issue an Advisory Letter for improper management.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-03-0246A	AMB	D. PAUL KNAPP, M.D.	22830	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure 5 years probation with parallel terms of the California Board Order. The Probation would begin upon the effective date of the Order.

Dr. Paul Knapp was present with legal counsel, Mr. Charles E. Buri.

Kelly Sems, M.D., Medical Consultant summarized the case. The Arizona Medical Board opened an investigation on May 12, 2003 after Dr. David Paul Knapp noted on his license renewal application that action had been taken against him in the state of Iowa. It was alleged that in 1996 Dr. Knapp failed to meet the standard of care for the practice of Dermatology, failed to maintain adequate medical records, and submitted claims that were not supported by the documentation. In addition, he prepared inadequate pathology reports, performed unnecessary pathologic analysis and improperly billed for services rendered. He also failed to monitor medication properly for a patient and provided inadequate supervision of his physician assistant.

In July 2000 Dr. Knapp entered into a settlement agreement with the Iowa Board of Medical Examiners. In August 2000 the New York Medical Board suspended his license after finding Dr. Knapp violated NY law in that he did not disclose the Iowa Board action by submitting a registration document that falsified his answer to a question concerning disciplinary charges and actions.

In November 2001 Dr. Knapp entered into an agreement with the Washington Board to comply with the terms and conditions imposed by the Iowa Board. In March, 2003 the Medical Board of California addressed the Iowa and New York Board's disciplinary actions as well as concerns regarding care provided to two California patients by both Dr. Knapp and his physician assistant. The California Board issued a stayed revocation for Dr. Knapp's license. The Iowa Board of Medical Examiners took additional action against Dr. Knapp's license in April 2004 based on the actions of the California and New York State Boards. The Iowa Board suspended his license for six months and placed his license on probation for five years.

On January 2004 the Arizona outside medical consultant reviewed the case and opined that Dr. Knapp failed to meet the accepted standard of care while practicing dermatology out of state. SIRC reviewed the case on November and recommended that the Board draft Findings of Fact, Conclusions of law for five years Probation with terms similar to the Iowa Board. In May 2005 at the Arizona Medical Board teleconference meeting the Board rejected the proposed Consent Agreement and invited Dr. Knapp for a Formal Interview.

On December 5, 2005 during the investigation process Staff discovered via the Iowa Board's website that additional charges had been filed against Dr. Knapp in April 2005 for violating the Iowa Board order.

Dr. Knapp said that most of these events occurred in 1995 and that he takes responsibility for his actions and has learned from them. He stated he has already followed his required plan for remediation and rehabilitation and has also done more than what was required of him. He said he as completed the PACE program through two separate avenues, has taken medical record courses and instituted medical record keeping systems. Additionally he has participated in a pathology quality assurance program where his pathology readings are over read and has attended the annual dermatology meeting for the last 10 years. Dr. Knapp said he is a much different physician than he was five years ago.

Dona Pardo, R.N., Ph.D. led the questioning. In response to Dr. Pardo's questions, Dr. Knapp said he is currently practicing in San Diego in a general Dermatology solo practice, where his staff consists of a receptionist and a transcriptionist. Dr. Knapp said his receptionist has training as an aesthetician, but that he performs the majority of the surgeries. Dr. Knapp said he does not have a physician assistant. He said he continues to interpret his own biopsy slides, but they are over read.

Dr. Pardo asked if there was any ethics training in the PACE course. Dr. Knapp said he thought there were approximately five hours included in the training.

Robert P. Goldfarb, M.D. noted Dr. Knapp's history was egregious. He said that although the physician claims he is rehabilitated, he does not know how the Board could feel comfortable with him practicing.

Mr. Buri, counsel for Dr. Knapp, said the problems in the physician's past were 5-10 years removed and Dr. Knapp has worked hard to rehabilitate himself, doing everything and more than what has been asked of him. Mr. Buri also said the monitoring reports from the California Board of Medical Quality Assurance will also attest to his competence.

MOTION: Dona Pardo, R.N., Ph.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(o) - Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of medicine, the doctor's medical incompetence or for unprofessional (q) - Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public. (e) - Failing or refusing to maintain adequate records on a patient. (ii) - Lack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed, certified or registered health care provider employed by, supervised by or assigned to the physician.
SECONDED: William Martin

Sharon B. Megdal, Ph.D. said she felt action should be taken to acknowledge the seriousness of the disciplines in the other states and to make the public of Arizona aware of the physician's prior history.

MOTION: Robert Goldfarb moved to Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure 5 years probation with parallel terms of the California Board Order. The Probation would begin upon the effective date of the Order.
SECONDED: Ronnie R. Cox, Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

CALL TO THE PUBLIC – 1:15 p.m.

Complainant K.C. was present and spoke to the Call to The Public regarding case numbers MD-04-1362A, Luis Coppelli, M.D and MD-04-1362B William Schwark, M.D. These cases were heard at the October 6-7, 2005 Regular Session Meeting.

K.C. said her stepmother was the patient in this case and died from a simple thyroidectomy. The medical examiner determined the cause of death in this patient was a result of surgery complications. She said there are many unanswered questions for her in this case and would like the Arizona Medical Board to find a way to release information to families about the investigative findings in order to provide closure for patients.

FORMAL HEARING MATTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-1544A	AMB	RICHARD J. REID, M.D.	19106	Accept the Findings of Fact, Conclusions of Law and Order for Revocation of License for habitual intemperance and violation of a Board Order.

William R. Martin, III, M.D. said he has worked with Dr. Reid but it will not affect his ability to adjudicate the case.

Neither Dr. Richard Reid nor counsel were present.

Dean Brekke, Assistant Attorney General presented the case to the Board on behalf of the State. Mr. Brekke said that while Dr. Reid was in the MAP Program he tested positive for Cocaine. He said Dr. Reid has not complied with his inpatient treatment requirement and so this matter was referred to formal hearing. The Administrative Law Judge recommends revocation of the license.

MOTION: Ram R. Krishna, M.D. moved accept the Findings of Fact, Conclusions of Law and Order for Revocation of License for habitual intemperance and violation of a Board Order.
SECONDED: William R. Martin, III, M.D.

MOTION: Patrick N. Connell, M.D. moved to make the Order effective immediately.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0171A	J.S.	CHARLES A. CALKINS, M.D.	9848	Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for performing the wrong surgery.

Charles Calkins was present without counsel.

William Wolf, M.D., Medical Consultant summarized the case. The patient alleged Dr. Calkins failed to remove a cyst on the right hand and failed to complete the procedure resulting in additional pain and scarring. The patient also alleged Dr. Calkins performed an unnecessary carpal tunnel release.

Dr. Wolf said the proposed standard of care requires that a surgeon performing a procedure insure both the patient and surgical site be properly identified prior to performing the surgery. The deviation was that Dr. Calkins performed a carpal tunnel release unnecessarily.

Dr. Calkins provided a brief summary of his response to the Board. He said the patient's surgical site was marked on the correct hand prior to surgery, but he misunderstood the procedure to be for carpal tunnel release and not for a cyst. After completing the carpal tunnel procedure he realized his error and then found and removed the cyst on the same hand. When patient awoke, Dr. Calkins said he was forthright with the patient and explained his error.

William R. Martin, III, M.D. led the questioning and asked Dr. Calkins to elaborate on what happened the day of the surgery. Dr. Calkins said he usually reviews the charts and x-rays the day of surgery. However, he incorrectly came to the misconception the patient was present for a carpal tunnel procedure and said he could not explain how he arrived at that incorrect assumption. Dr. Calkins said it is also his practice to meet briefly with the patient before the procedure, but this case was different because the patient had surgery by a podiatrist first and Dr. Calkins came in while the patient was still under anesthesia and performed his procedure after the podiatrist. Dr. Calkins said he believed a second reason he did not meet with the patient prior to surgery was because he got caught up in the rush of the day.

Paul M. Petelin, M.D. asked if the facility Dr. Calkins works at has a procedure in place to take a pause in the operating room, when all professionals assisting are present and everyone agrees on the type of surgery they will be performing. Dr. Calkins said their facility does have that procedure in place, but the policy failed with this patient. Dr. Calkins said he spoke to a staff member earlier in the day about his understanding that the patient's procedure was for carpal tunnel, but the staff member did not correct him. He said he has since made sure the routine pause is never missed prior to surgery.

Tim B. Hunter, M.D. asked what Dr. Calkins has done to prevent this occurrence from happening again. Dr. Calkins said he now speaks with the patient just prior to surgery to confirm the procedure, does a strict time-out before surgery with the staff in the operating room, and reviews his charts thoroughly beforehand.

William R. Martin, III, M.D. said he believes by the physician's own admission there has been unprofessional conduct, specifically performing wrong surgery.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(q) - Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Tim B. Hunter, M.D. noted the physician's records were forthright.
William R. Martin, III, M.D. said the testimony before the Board was also forthright, which can be mitigating, but the incident still occurred.

MOTION: William R. Martin, III, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for performing the wrong surgery.
SECONDED: Patrick N. Connell, M.D.

Paul M. Petelin, M.D. asked if the Board would consider an Advisory Letter because the physician was forthright. Dr. Martin noted the occurrence was both a system failure and individual failure and must be acted firmly upon. Dr. Hunter said this type of error happens to the finest of physicians, but the Board has been firm on its stance in these types of cases.

Dona Pardo, R.N., Ph.D. suggested this case also be referred to the Nursing Board.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D. The following Board Member voted against the motion: Paul M. Petelin, M.D.
VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
Motion Passed.

MOTION: Ram R. Krishna, M.D. moved to refer the matter to the Nursing Board.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-04-0894A	AMB	CHARLES BOLLMANN, M.D.	6020	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and three-year Probation to include 20 hours CME related to boundary issues and ethics for admitted sexual conduct with patients and admitted self medicating. Physician must obtain a psychosexual evaluation with counseling as appropriate. Physician may request termination after one year.

Dr. Charles Bollman was present without counsel.

Patricia Reynolds, Assistant Manager, Office of Investigations summarized the case. Board staff received an anonymous complaint alleging Dr. Bollmann engaged in sexual conduct with multiple female patients. The complainant further alleged Dr. Bollman self-medicated with Xanax that he obtained from his office. The investigation found Dr. Bollman admitted to engaging in sexual conduct with six patients and marrying three of them. He also indicated he self-medicated Xanax for sleep during periods of stress.

Arizona Medical Board Staff offered Dr. Bollmann a Consent Agreement which he signed. However, during the October 6-7, 2005 Board meeting, the Board voted to reject the proposed Consent Agreement and offer a revised Consent Agreement. Dr. Bollmann rejected the revised Consent Agreement and elected to appear before the Board for a Formal Interview.

Dr. Bollman summarized his response by referring to a letter he had from another physician who advised him to take Xanax to help him sleep. He said he only takes the medication at night, and has never used it during the day. He said he had a prescription from a physician previously, took samples after the prescription ran out, and since receiving notice of this case, has obtained another prescription. Dr. Bollmann said he is now aware he cannot self-prescribe controlled medications.

Dr. Bollman also spoke to the fact that he had dated patients. He said he was not aware there was a statute against this and had considered the moral portion of his actions rather than the ethical portion, since he had not dated anyone who was married or while he was married.

Sharon B. Megdal, Ph.D. led the questioning and asked if the three patients he married were patients prior to his marriage. Dr. Bollmann said one woman became his patient after they began dating, the other had been a friend for 20 years, and the other patient had not been seen for two years his office at the time they began dating.

Patrick N. Connell, M.D. asked the physician whether being on call should prevent him from taking Xanax at night. Dr. Bollmann said he takes very little Xanax and takes it infrequently.

MOTION: Sharon B. Megdal, Ph.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(g) - Using controlled substances except if prescribed by another physician for use during a prescribed course of treatment. (z) - Engaging in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating or engagement relationship with the licensee, for purposes of this subdivision, "Sexual Conduct" includes:
(i) Engaging in or soliciting sexual relationships, whether consensual or nonconsensual.
(ii) Making sexual advances, requesting sexual favors or engaging in other verbal conduct or physical contact of a sexual nature.
(iii) Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.

SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent

MOTION: Sharon B. Megdal, Ph.D. moved to issue a Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure and three-year Probation to include 20 hours CME related to boundary issues and ethics for admitted sexual conduct with patients and admitted self medicating. Physician must obtain a psychosexual evaluation with counseling as appropriate. Physician may request termination after one year.
SECONDED: Dona Pardo, R.N., Ph.D.

Ram R. Krishna, M.D. noted there was no patient harm and the goals Dr. Megdal mentioned for rehabilitation could be accomplished with a Letter of Reprimand.

AMMENDED MOTION: Ram R. Krishna, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and three-year Probation to include 20 hours CME related to boundary issues and ethics for admitted sexual conduct with patients and admitted self medicating. Physician must obtain a psychosexual evaluation with counseling as appropriate. Physician may request termination after one year.
SECONDED: Patrick N. Connell, M.D.

Dr. Lee spoke against the motion because he felt the physician's sexual problems were more boundary issues than true psychosexual problems.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Paul M. Petelin, M.D. The following Board Members voted against the Motion: Douglas D. Lee, M.D., Dona Pardo, R.N., Ph.D. The following Board Member abstained: Ronnie R. Cox, Ph.D.
VOTE: 9-yay, 2-nay, 1-abstain 0-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-04-1108A	AMB	TERRY R. MAXON, M.D.	4717	Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to properly monitor and treat a patient with a gastrointestinal (GI) bleed resulting in the demise of the patient.

Terry Maxon was present with counsel, Ms. Suzanne Ogden Esq.

Mark Nanney, M.D., Chief Medical Consultant summarized the case. The patient was a 68-year-old female who presented with a GI bleed. Dr. Maxon evaluated her and noted that she was passing bloody stool at a fairly frequent rate, was rather pale and a little bit tachycardic. She also noted the patient had falling hemoglobin going from 10.3 to 8.1. The patient's medical status was complicated by aortic stenosis. Dr. Maxon recommended a nuclear medicine study to determine the source of the bleeding. The nuclear medicine study was aborted because the patient was hemodynamically unstable. The patient reported to the nurse on the floor that she had had a panic attack while in radiology. It appears that Dr. Maxon was not notified of the problems in radiology. The patient later had a heart attack.

Dr. Maxon responded that the patient's bleeding was active, but not brisk. He states he was informed by the nurse that the nuclear medicine study was cut short because of a panic attack. He said he had no reason to believe the patient had a more serious complication than a panic attack. Dr. Maxon said the Outside Medical Consultant said the standard of care required the patient be transfused if the hemoglobin was less than 10. Dr. Maxon said he provided the Board with an article from the New England Journal of Medicine disagreeing with that standard.

Paul M. Petelin, M.D. led the questioning. Dr. Petelin noted Dr. Maxon ordered maintenance IV rather than resuscitation IV. Dr. Maxon contended his IV was for resuscitation of the patient and that 125 cc per hour is a significant amount of fluid for a patient who was still drinking water and eating. Dr. Petelin noted his disagreement with Dr. Maxon on this point.

Dr. Petelin noted Dr. Maxon was aware of the patient's third episode of bleeding, but yet did not act as aggressively as would be expected. Dr. Maxon said the patient's bleeding would start and stop and that it was hard for him to evaluate the patient when she was not bleeding. He said the patient was on her way to have the radioactive scan to try to localize the site of bleeding when she passed out. He does not remember the nurse calling him, but said the nurse must have told him something to the effect of, the patient had a panic attack, her blood pressure is okay, her pulse is okay and her oxygen saturations are fine. Dr. Maxon said he was unaware the patient had become unstable in the scanner.

Dr. Mackstaller said she could tell from the echocardiogram that the patient had an enlarged heart. She said she was concerned that Dr. Maxon did not seem to pick up on the factors that because the patient was bleeding, was on a beta blocker and was hypotensive, that the patient may be having a heart attack or at least ischemia.

Dr. Maxon stated he did not believe the patient died from bleeding, but from a heart attack. He said he did not think the blood loss she suffered could have caused a heart attack, but that possibly the IV fluids the hospital gave to the patient may have influenced the heart attack.

Dr. Maxon said this incident has not changed his practice because he has been in the field for 30 years and has never had a patient die from gastrointestinal bleeding. He said this patient's case was very different from a patient who dies from bleeding.

Douglas D. Lee, M.D. asked Dr. Maxon why he was not alarmed by the patient's falling hemoglobin. Dr. Maxon said at the time the hemoglobin was falling, he incorrectly read the labs because the hospital had changed their procedure and the labs were listed in reverse order. He said he was not alarmed that it appeared the numbers were off because they go up and down frequently in a number of patients and he often repeats labs to obtain a consensus of readings.

Ms. Ogden, Dr. Maxon's counsel, said Dr. Maxon acted appropriately based on the information he had at the time.

Dr. Petelin said he finds grounds for unprofessional conduct and is in strong disagreement with Dr. Maxon on the IV fluid rate. He said that 25 cc's an hour in a 70 kilogram female is maintenance and that he didn't see any attempts at resuscitation by Dr. Maxon for the patient. Dr. Petelin said that even allowing for the failure to resuscitate, there was a red flag on the patient's nuclear medicine scan. He said he did not know what the communication was between Dr. Maxon, the radiologist and the nurse, but even without the knowledge of hindsight, a blood pressure of 70, and an O2 saturation of 75% cannot be contributed to a panic attack.

MOTION: Paul M. Petelin, M.D. moved for a finding of Unprofessional Conduct for failure to document lower GI bleeding in an elderly patient and failure to transfuse the patient in violation of A.R.S. § 32-1401(27) (q) - Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public (ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 10-yay, 1-nay,1-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Petelin said it takes time for an equilibration to occur. He said if the equilibration is not treated with IV fluids, it can take up to 24 hours before drop is seen in the hemoglobin, but if aided with IV fluids, the hemoglobin will drop in matter of a few hours. He said the deviation in the standard of care was failure to recognize the seriousness of this GI bleeding and treat it appropriately in a timely manner. Additionally, the patient should have been transferred to a higher acuity level of care.

MOTION: Paul M. Petelin, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to properly monitor and treat a patient with a gastrointestinal (GI) bleed resulting in the demise of the patient.
SECONDED: Ram R. Krishna, M.D.

Dr. Connell spoke against the motion. He said this was a complicated patient, a hemoglobin of 8 is appropriate, and it is true that IVs can easily over hydrate a patient. He said he does not find the compelling evidence that he deviated substantially from the standard of care.

Dr. Mackstaller said she felt the problems were all interrelated and the patient was a high-risk patient.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, M.D. The following Board voted against the motion: Patrick N. Connell, M.D. The following Board Member abstained from voting: William R. Martin, III, M.D.
VOTE: 10-yay, 1-nay, 1-abstain 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-0540A MD-04-0459A MD-05-0253A	AMB AMB A.M.	THOMAS J. GRADE, M.D.	10424	Summarily restrict the physician's license to prohibit prescribing of Schedule II and Schedule III drugs.

Dr. Richard Ruskin, physician's friend spoke on behalf of Dr. Grade. He said Dr. Grade has been in practice for 25 years and has some of the hardest pain management patients. He said the patients are not always upfront in their past medical history, but knows the gravity of this case and can attest Dr. Grade does his best to take care of patients.

Dr. Emily Grade, wife of Dr. Grade spoke on behalf of Dr. Grade. She said she has sat on a hospital Board and has never heard anything derogatory about Dr. Grade. She said she knows he cares for his patients and is deeply affected by the incidents in these cases. She said both Dr. Grade and her personal medical group have implemented changes due to this incident.

Dr. Thomas Grade was present with legal counsel Ms. Lisa Davis.

Kelley Sems, M.D., separated the three cases and began her presentation with case MD-05-0253A, per the Board's request. The case was opened on May 13, 2005 alleging Dr. Grade excessively prescribed narcotics to patient L.M., resulting in her death. It was also alleged he falsified the medical record to hide the fact that the patient was scheduled to have surgery for battery replacement. The Medical Consultant reviewed the case and found Dr. Grade's documentation to be inadequate. The Consultant also found the initial Methadone dose was excessive, and there was a conflict between what was written on Dr. Grade's April 20, 2004 office notes and the prescription instructions. In addition, the record shows he did not discuss advice and cautionary warnings with the patient regarding the use of Methadone.

The patient later expired and the autopsy found the death was due to multiple drug toxicity. An outside medical consultant, who was a clinical toxicologist, also reviewed this case and opined the initial does of Methadone prescribed by Dr. Grade was excessive. He agreed the most likely cause of death was drug toxicity suspecting it could have been from the Methadone alone or in combination with other medications that the patient was taking.

Robert P. Goldfarb, M.D. led the questioning. Dr. Grade stated he was very saddened by this case and that since the complaints he has changed his practice considerably.

Dr. Grade said the patient was referred to him, but he did not discuss with the patient's history with the referring physician. He said it was not unusual for him to take a new patient without discussing their care with the referring physician, but he has now changed his practice in this area. Dr. Grade said he presumes patients tell him the truth about the medications they are taking and it did not occur to him the patient was being dishonest. He said the patient was very knowledgeable and had practiced as an R.N. in another state. Dr. Grade said he currently has about 400 patients he manages on Methadone.

Dr. Goldfarb asked Dr. Grade why it did not concern him that he began with such a large doses of Methadone on the first day. Dr. Grade replied that he thought the patient may have evidence of tolerance and also felt a large does was acceptable because he was not aware the patient did not list all the medications she was using.

Dr. Grade said although it appears he dictated the patient's consultation after her death, the consultation of April 20, 2004 was dictated on April 29, 2004, but transcribed on May 12, 2005. Dr. Grade said there is evidence in the medical chart of the day of his dictation. He said he now dictates in front of the patient.

Patrick N. Connell, M.D. noted Dr. Grade did not asses the patient regarding her level of depression because Dr. Grade said he did not believe the patient to be depressed although she had recorded depression on the questionnaire she filled out prior to her initial appointment.

Dr. Goldfarb noted the prescription given by Dr. Grade and the prescription amount noted on the dictation were contradictory.

The Board went into Executive Session 6:39 p.m.
The Board returned to Open Session at 6:44 p.m.

Tim B. Hunter, M.D. commented that the patient presented to Dr. Grade for a change of battery, but instead he assumed control of her entire pain management without having her previous medical records.

Dr. Grade said he has done several things to change his practice; he has been transitioning from paper to electronic medical records and now dictates his medical records in front of patients to be more thorough and timely.

Ms. Davis said Dr. Grade clearly cares about his patients although he admits a weakness in not having more thorough medical records to show he discussed cautionary warnings with the patient. She said he also admits weakness that he did not review the patient's previous history.

Ms. Davis said Dr. Grade now takes even more CME on pain management, dictates his notes at the time of each visit, has had external and internal audits of his charts and has reviewed the pain management protocols of the Board. Ms. Davis said the practice has also revised their Opioid agreements, and now require patients to take random urine samples. Patients also cannot ask for changes in Opioid doses over the phone and cannot get early refills. Finally, patients can only use one pharmacy or their pain agreement will be terminated.

Dr. Goldfarb said he is concerned about serious lapses based on the other two cases against Dr. Grade that were provided to the Board for today's meeting and by Dr. Grade's testimony in this case.

MOTION: Robert P. Goldfarb, M.D. moved to summarily restrict the physician's license to prohibit prescribing of Schedule II and Schedule III drugs.
SECONDED: Patrick N. Connell, M.D.

Dr. Connell said he finds Dr. Grade's testimony to be lacking especially since he has testified he has had additional CME and training in pain management since this incident. Ronnie R. Cox, Ph.D. said he felt the mistakes made in this case were a result of a lack of elementary knowledge.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Paul M. Petelin, M.D. The following Board Member voted against the motion: Tim B. Hunter, M.D., The following Board Member abstained from voting: Lorraine Mackstaller, M.D., The following Board Member was absent: William R. Martin, III, M.D.
VOTE: 9-yay, 1-nay, 1-abstain 0-recuse, 1-absent
MOTION PASSED.

Ms. Davis objected that a decision was made without the other two cases being heard by the Board and stated it was a violation of Dr. Grade's due process rights.

Christine Cassetta, Legal Counsel noted for the record that the Board followed appropriate procedure for a Summary Action.

THURSDAY, DECEMBER 8, 2005

CALL TO ORDER

Tim B. Hunter, M.D. called the meeting to order at 8:00 a.m.

ROLL CALL

The following Board Members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, M.D.

Ronnie R. Cox, Ph.D. arrived at the meeting at 9:30 a.m.

CALL TO THE PUBLIC

Statements issued during the Call to the Public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0949A	AMB	JAMES D. GADD, M.D.	8696	James D. Gadd, M.D., Draft Findings of Fact Conclusions of Law and Order for three year Probation to not practice medicine. He must successfully complete inpatient treatment. Upon completion of inpatient treatment, he may apply to the Board to return to the practice of medicine and entrance MAP. At the end of three years if he does not successfully complete inpatient treatment the case shall be referred to formal hearing for revocation.

William R. Martin, III, M.D. said he knows Dr. Gadd but it will not affect his ability to adjudicate this case.
Patrick N. Connell, M.D. said he knows Mr. Cal Raup but it will not affect his ability to adjudicate this case.

Dr. James Gadd was present with counsel, Mr. Cal Raup.

Kathleen Muller, Physician Health Program Manager presented the case to the Board. In 1978 Dr. Gadd participated for one year in a program under the guidance of the Physician's Rehabilitation Committee and received treatment at that time. However, the treatment was primarily psychiatric rather than treatment for chemical dependency.

In 2003 Dr. Gadd completed treatment at the Betty Ford Center for his use of Fentanyl, Lortab and Alcohol. He entered the Monitored Aftercare Program (MAP) under a Consent Agreement for Probation. His agreement stated that in the case of relapse his license would be revoked.

On August 3, 2005, Dr. Gadd's urine specimen was positive for Fentanyl that he admitted to using.

This case was discussed at the October 6-7, 2005 Board Meeting and the Board recommended the case be brought forward to the December meeting to determine if Dr. Gadd's August 3, 2005 relapse was or was not his 3rd strike under the Board's current policy.

Patrick N. Connell, M.D. led the questioning. Dr. Gadd said he was self-prescribing Dexedrine in 1978 and Valium and was not using any anesthesia drugs at that time. In 2002 he began using Fentanyl and other opiates. He explained his relapse in 2005 was during a time when he had been taking Naltrexone, an opiate blocker, and was scheduled for some minor surgery. Dr. Gadd said he was concerned the medications used on him during surgery would not be effective and so he tried Fentanyl to make sure the Naltrexone was out of his system. Dr. Gadd said he was called the following day for a random urine specimen as part of his MAP agreement.

Dr. Connell noted Dr. Gadd's reasoning depicted that of someone who was impaired with the illness of chemical dependency. Dr. Connell noted Dr. Gadd had not returned to Betty Ford or a similar in-patient facility for treatment following his relapse.

Sharon B. Megdal, Ph.D. asked Dr. Sucher what other actions Dr. Gadd could have taken to determine if the Naltrexone was out his system. Dr. Sucher said Dr. Gadd could have submitted for a drug screen, but that Dr. Gadd's reasoning demonstrates a classic example of addictive thinking.

Tim B. Hunter, M.D. asked Dr. Gadd what plans he had to get back on track. Dr. Gadd said he goes to A.A. Meetings, has been exercising 1-2 hours a day. Dr. Gadd said he knows his return to the practice of Anesthesia is very remote and so is considering administrative medicine in the future.

Dr. Sucher said he believes Dr. Gadd is currently not safe to return to the practice of medicine, even administratively, and that the rehabilitation success of impaired anesthesiologists across the nation was very remote. Dr. Sucher said Betty Ford did an evaluation on Dr. Gadd in September 2005 and recommended he return for in-patient treatment. He said Dr. Gadd does not wish to participate in in-patient treatment and could alternatively attend AA Meetings for 1-2 years and show a pattern of recovery to Board. Dr. Sucher said there is a much smaller likelihood of success when inpatient treatment is not done. Dr. Sucher also commented that the current entrance into MAP requires the physician have successfully completed treatment.

Dr. Gadd said he has enormous financial restraints and cannot afford inpatient treatment at this time. He said he does not feel another inpatient treatment would be helpful because he knows what his errors are.

The Board went into Executive Session at 8:35 p.m.
The Board returned to Open Session at 8:40 a.m.

Dr. Connell said he acknowledges the clause in the physician's Consent Agreement stating the license would either be revoked or surrendered in the case of relapse. He said it is clear that the physician relapsed, but the evidence shows he did not receive sufficient treatment for recovery in 1978, indicating a relapse could not be present until recovery was first in place.

Douglas D. Lee, M.D. said he believed if the Board mandated rehabilitation, they should make the time period succinct enough that they are not leaving the responsibility of this case to another Board. He said a future Board may not know their concern voiced in this meeting that the physician never return to the practice of anesthesia.

MOTION: William R. Martin, III, M.D. moved to Draft Findings of Fact Conclusions of Law and Order for 3 year Probation to not practice medicine. He must successfully complete inpatient treatment. Upon completion of inpatient treatment, he may apply to the Board to return to the practice of medicine and enter MAP. At the end of 3 years if he does not successfully complete inpatient treatment the case be referred to formal hearing for revocation.
SECONDED: Paul M. Petelin, M.D.

Dr. Connell said he has seen several cases of outpatient treatment for two years with an immediate relapse. He said he does not feel outpatient treatment is effective.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D, Paul M. Petelin, M.D.
The following Board Member abstained: Becky Jordan The following Board Member was absent: Ronnie R. Cox, Ph.D.
VOTE: 10-yay, 0-nay, 1-abstain 0-recuse, 1-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-1477A	R.S.	ANTHEA DIXON, M.D.	11202	Draft Findings of Fact, Conclusions of Law and Order for Letter of

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					Reprimand for failure to identify a large mass and a large amount of fluid in the abdomen.

Lorraine Mackstaller, M.D. and Robert P. Goldfarb, M.D. recused themselves from this case.

Anthea Dixon, M.D. was present with legal counsel, Mr. Tom Slutes Esq.

Ingrid Haas, M.D., Medical Consultant presented the case to the Board. This matter came to the attention of the Board through a complaint from R. S. alleging Dr. Dixon had failed to diagnose ovarian cancer and failed to evaluate her swollen left ovary and fluid within the abdomen. The 87-year-old patient presented to Dr. Dixon's office in June 2001 after her massage therapist had told her she had a swollen ovary and fluid in the abdomen that should be evaluated. She said Dr. Dixon reported the examination as a normal pelvic exam. Patient R.S. said she complained to Dr. Dixon about urinary frequency and pressure but no testing was ordered. In August 2001 the patient's primary care physician diagnosed stage 3 ovarian cancer and a 16 centimeter mass. Dr. Dixon stated that she assumed other physicians were evaluating the patient.

Dona Pardo, Ph.D., R.N. led the questioning. Dr. Pardo verified only four pages of medical records were available for the Board's review from Dr. Dixon's treatment. Dr. Dixon's notes show she palpated the abdomen and did not find any abnormalities. Dr. Dixon said she was primarily looking for abnormalities in the bladder because she knew the patient had an abdomen procedure performed by another physician within a short time of her seeing the patient. She said she does not recall the patient telling her about the massage therapist's findings of a mass.

Dr. Pardo noted that the Outside Medical Consultant felt Dr. Dixon fell below the standard of care although Dr. Dixon does not feel she deviated.

Paul M. Petelin, M.D. noted it was hard to tell what type of abdominal exam was performed on the patient because the medical records are sparse.

Ram R. Krishna, M.D. noted Dr. Dixon felt the patient had been followed by other physicians and did not assume full care. He noted the patient had been seen by an urologist three days earlier.

Dr. Pardo said it was hard for her to understand if Dr. Dixon had done a good palpation of the abdomen why she would not have found the mass. She said she did not find actual patient harm, but does find potential harm. Dr. Pardo said the standard of care is to perform an accurate physical exam.

MOTION: Dona Pardo, R.N., Ph.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(q) - Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 10-yay, 0-nay, 0-abstain 2-recuse, 0-absent

MOTION: Dona Pardo, R.N., Ph.D. moved to Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to identify a large mass and a large amount of fluid in the abdomen.

Dr. Petelin said he favored a non–disciplinary action such as an Advisory Letter, because the physician has no prior disciplinary action and there were other physicians overseeing the patient's care at the same time who found the mass. William R. Martin, III, M.D. said he agreed with Dr. Petelin's comments because there was no patient harm in this case.

Dr. Krishna commented, on the contrary, it was fortunate other physicians were involved in the patient's care because the physician clearly misdiagnosed the patient.

Dr. Megdal said trust is placed in gynecologist, in this type of situation, to discover the mass.

SECONDED: Sharon B. Megdal, Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ronnie R. Cox, Ph.D., Becky Jordan, Ram R. Krishna, M.D. Douglas D. Lee, M.D. Sharon B. Megdal, Ph.D. Dona Pardo, R.N., Ph.D. The following Board Members voted against the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., William R. Martin, III, M.D., Paul M. Petelin, M.D. The following Board Members recused themselves from the case: Robert P. Goldfarb, M.D., Lorraine Mackstaller, M.D.
VOTE: 6-yay, 4-nay, 0-abstain 2-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0496A	H.D.	DANIEL M. LIEBERMAN, M.D	28519	Dismissed

Robert P. Goldfarb, M.D. said he knows Mr. Milligan but it will not affect his ability to adjudicate the case.

H.D., the wife of the deceased patient was present and spoke. She said that prior to the deep brain stimulation (DBS) procedure, Dr. Lieberman told her and her husband there was a 98% chance the procedure would be successful. H.D said immediately following the surgery her husband had immediate significant memory loss. She said Dr. Lieberman said her husband kept falling asleep during the

surgery, and that the operation required the patient to be awake. She also said Dr. Lieberman told her husband was the first patient he lost. H.D. also claimed Dr. Lieberman told her he had to make several passes through the patient's frontal lobe and H.D. asked the Board if that was standard of care.

Daniel Lieberman, M.D. was present with counsel, Mr. Bob Milligan Esq.

Kelly Sems, M.D., Medical Consultant summarized the case for the Board. On April 20, 2004 the Arizona Medical Board received a complaint from H.D. regarding the care provided to her husband, J.D., by Dr. Lieberman. It is alleged Dr. Lieberman failed to perform neuro-psychiatric testing prior to deep brain stimulation surgery and negligently performed deep brain stimulation surgery resulting in permanent brain damage. The complaint felt the DBS ultimately resulted in the death of her husband.

An outside medical consultant reviewed the case and concluded Dr. Lieberman did not perform an adequate preoperative evaluation and failed to evaluate for dementia, which is contraindicated in deep brain stimulation surgery. He noted Dr. Lieberman had two separate dictations for the first surgery performed on July 7, 2003 separated in time by three and a half months and containing different accounts of what transpired at surgery.

Finally, he concluded that Dr. Lieberman failed to locate the subthalamic nucleus (STN) with a minimum of microelectrode penetrations and failed to place the electrode in the appropriate locations. Actual harm was identified in that Dr. Lieberman either induced or exacerbated dementia in this patient.

Dr. Lieberman said he thought the patient an excellent candidate for deep brain stimulation, but did not tell the family there was a 2% chance for complications. He said it is true the operation has to be done with the patient awake, and that the patient did not actually fall asleep, but rather had to be gently aroused on a couple of occasions when he started to become too relaxed. Dr. Lieberman said he made five passes through the patient's frontal lobe, but this is not unusual in this type of procedure. He said multiple passes were made because he was unable to find the target.

Dr. Lieberman said the patient was confused after the procedure, but that it was expected for this type of an elderly patient. The patient came back one month later to repeat the procedure on the right side of the brain. Dr. Lieberman said the placement was not perfect, but he did not consider that to be a complication or a gross error. He said that after the procedure he believed the patient to be making a steady recovery. However, he said the patient later took a turn for the worse.

Robert P. Goldfarb, M.D. led the questioning. Dr. Lieberman said he believes he has unique qualifications for the DBS procedure and was the busiest DBS surgeon in the valley prior to this complaint, since which time he has stopped performing the procedure.

Dr. Goldfarb asked Dr. Lieberman to explain his two separate operative reports. Dr. Lieberman said the first report was done at his office with an electronic system he had been using. However, three months later the hospital told him they could not accept his reports in this format and asked that the reports be resubmitted. He said he then sat down with the file and dictated to the best of his recollection. He said he realized now that it would have been prudent for him to get the report from his office and read it into the dictation machine.

Dr. Goldfarb asked Dr. Lieberman to explain why he felt the patient passed away. Dr. Lieberman said he speculated the patient had some other problems in addition to his Parkinson's disease because he believes dementia and delirium alone would not cause death six months after surgery. He said he has never seen death as a complication in any other case of this nature and could only guess the patient had some other neurological process.

Dr. Lieberman said he did the best he could with the information he had, and even in hindsight does not believe anyone could have done better.

Dr. Goldfarb noted that for the allegation of inadequate pre-op evaluation prior to surgery, there is no standard of care, but rather various physicians have there own procedures. He also noted most of the Parkinson's patients go to the neurosurgeon by referral from the neurologist who has done a thorough evaluation and so he found the inadequate workup allegation could not be sustained.

Dr. Goldfarb noted that for the second allegation of negligently performing DBS resulting in brain damage, the Outside Medical Consultant said the complications are rare, but appear in the best of hands. Dr. Goldfarb also noted that five passes through the brain is not below the standard of care and that allegation cannot be sustained.

Dr. Goldfarb also did not find cause to sustain the third allegation of inadequate records on the patient. He said the first operative report discusses what happened during surgery and the report seems very accurate. He said the explanation for the differing second report seems legitimate since if the physician would have been trying to cover something up, he would have destroyed his first report.

Dr. Goldfarb said he could not find anything in the record or allegations that anything occurred during surgery that was below the Standard of Care.

MOTION: Robert P. Goldfarb, M.D. moved to dismiss the case.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-04-0186A MD-04-0925A	PSYCH BOARD W.F.	HOWARD L. MITCHELL III, M.D.	30004	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate prescribing and monitoring of medications, specifically amphetamines, and ignoring data when evaluating a patient and making a custody recommendation without an appropriate evaluation. One Year Probation for 20 hours CME in pharmacology in addition to CME required for license renewal.

Dr. Howard Mitchell, III was present without counsel.

Sharon B. Megdal, Ph.D. recused herself from the case.

Christine Cassetta, Legal Counsel informed the Board that this was a continuation of the formal interview held at the October 6-7, 2005 Board Meeting.

The Board members considered the Draft Findings of Fact, Conclusions of Law and Order and Order presented by Ms. Cassetta and discussed whether Probation with CME would be appropriate.

MOTION: Robert P. Goldfarb, M.D. moved to issue Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate prescribing and monitoring of medications, specifically amphetamines, and ignoring data when evaluating a patient and making a custody recommendation without an appropriate evaluation. One Year Probation for 20 hours CME in pharmacology in addition to CME required for license renewal.
SECONDED: Douglas D. Lee, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, M.D. The following Board Member abstained from voting: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 1-abstain 0-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-04-0720A	R.D.	ZELALEM YILMA, M.D.	25431	Issue an advisory letter for failure to document a major complication of surgery. This is a minor technical deviation that does not rise to the level of discipline.

J.H.C., husband of the patient, was present and spoke during the Call to the Public. He said the Board discussed in general whether dual and single chambered pacemakers are better than the other in their last meeting. However, he said that is a moot point in his wife's case. He said his wife's lower heart was not working with the upper heart and that was why the dual chamber pacemaker was prescribed by Dr. Yilma's colleague. He said his wife had multiple health problems after receiving the single pacemaker. He said that his wife now has a better quality of life with the dual chambered pacemaker.

Dr. Zelalem Yilma was present with counsel, Mr. Stephen W. Meyers Esq.

William Wolf, M.D., Medical Consultant presented the case to the Board. He said the Board heard the case at the October 6-7, 2005 Board Meeting at which time the Board noted there was inadequate documentation in the medical record of the patient's bleeding complication during surgery. The matter was continued so the physician could be re-noticed on the documentation issue.

Dr. Yilma said it would be inadequate to say she did not appropriately document the patient's bleeding because that was the whole focus of the patient's hospital stay.

Robert P. Goldfarb, M.D. led the questioning and noted it was Dr. Yilma's testimony at the October 6-7, 2005 Board Meeting that the patient's procedure was aborted because there was considerable bleeding. However, Dr. Goldfarb noted Dr. Yilma's hospital progress notes, done immediately after the procedure, noted the procedure was successful and do not indicate she aborted the procedure or why she aborted the procedure. Dr. Goldfarb said that any physician attempting to follow this patient would not know how to proceed correctly because the complication would have been unknown to another physician. Dr. Yilma said the hematocrit drop would indicate bleeding to another physician.

Paul M. Petelin, M.D. noted that if the patient coded the evening of her surgery and Dr. Yilma was not available, staff would not have known what the code was caused from. Dr. Lee noted that even though Dr. Yilma did not know what the complication was caused from, she could

have recorded some speculation in her medical records. Dr. Mackstaller said there were no pertinent negatives recorded in the medical record and that it may have been pertinent to record that the pacemaker was inserted correctly.

Dr. Goldfarb said that by Dr. Yilma's testimony, she does not believe a major complication needs to be part of the operative report or progress notes.

MOTION: Robert P. Goldfarb, M.D. moved to issue an advisory letter for failure to document a major complication of surgery. This is a minor technical deviation that does not rise to the level of discipline.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. The following Board Member voted against the motion: Paul M. Petelin, M.D. The following Board Members abstained: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Dona Pardo, R.N., Ph.D.
VOTE: 8-yay, 1-nay, 3-abstain 0-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-04-1493A	AMB	NATHAN A. BENSON, M.D.	11943	Issue an Advisory Letter for inappropriate postoperative fluid management. This was a technical one-time error.

Douglas D. Lee, M.D. recused himself from the case.

Dr. Nathan Benson, M.D. was present with counsel, Mr. Peter Wittekind.

Gerald Moczynski, M.D., Medical Consultant summarized the case. The Arizona Medical Board opened this case after receiving notification from the National Practitioner Data Bank of a malpractice settlement for Dr. Benson. The patient was a 56-year-old male who had a chronic history of obstructive urinary symptoms of two years duration with failure of conservative care. The patient had a transection of the prostate and a hernia repair on April 4, 2000. The post-op orders by Dr. Benson were for a general diet and continuous IV fluids of 150 C's per hour of D5 one quarter normal saline. The patient was seen the next day on April 5th, 2000 and Dr. Benson's orders were to discontinue the Foley catheter and to discontinue the IVs when the patient was tolerating fluids. Later that day the patient complained of chest pain and a cardiology consult was obtained. The next morning it was documented the patient had had three episodes of emesis before being seen. Dr. Benson had evaluated the patient on the second post-operative day, April 6, 2000 and was arranging for discharge when the patient had a seizure. The patient was transferred to cardiology service and while getting a CT scan, the patient suffered a second seizure requiring intubation and mechanical ventilation. The patient suffered a permanent brain injury from the second seizure and apparent anoxia. Subsequent serum sodium was reported of that morning as 118.

An outside medical consultant reviewed the case and opined that Dr. Benson failed to monitor serum sodium concentration in a patient at risk for developing high hyponitremia. He failed to diagnose hyponitremia in a timely fashion and he inappropriately administered hypotonic solution to a post-operative patient.

Dr. Benson summarized the case by stating he had been following the patient for two years. The patient had two surgeries performed on the same day, a hernia surgery by a separate physician first and Dr. Benson's prostate surgery second. Dr. Benson said he saw the patient in the recovery room, but did not make a note in the chart because he planned to come back in a couple hours to discharge the patient. After leaving the recovery room he received a call that the patient was having chest pain. He ordered an EKG and the Cardiologist did not see this as a major cardiac event. The next morning the patient appeared to be in stable condition. Shortly after, the patient had a seizure.

Lorraine L. Mackstaller, M.D. led the questioning. Dr. Benson said he has had one death in the entire time he has performed prostate surgeries. He said he has performed an average of one prostate surgery per week for the past 25 years. He said he does not normally check serum sodium concentrations after performing surgeries and he did not believe the patient was having any symptoms of hyponitremia. Dr. Benson said the patient's wife said she detected mental change in her husband, but this information was not relayed to him from the nurse. Dr. Benson said he believed the quarter normal saline partly caused the hyponitremia.

Dr. Benson said this has changed his practice in that now when he is told a patient is nauseated he will then instruct staff to watch for mental changes.

Paul M. Petelin, M.D. noted his disagreement with Dr. Benson using quarter strength saline on a patient who was taking oral fluids as well.

MOTION: Lorraine Mackstaller, M.D., Ph.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Paul M. Petelin, M.D.

MOTION: Lorraine Mackstaller, M.D. moved to Issue an Advisory Letter for inappropriate postoperative fluid management. This was a technical one-time error.
SECONDED: Ram R. Krishna, M.D.

Dr. Petelin spoke against the motion, saying he felt Dr. Benson may be lacking some basic knowledge in fluid electrolyte management and the diagnosis and treatment of electrolyte deficiencies. He also said he did not believe Dr. Benson had an awareness of what constitutes the composition of quarter strength saline.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D. The following Board Members voted against the motion: Robert P. Goldfarb, M.D., Sharon B. Megdal, Ph.D., Paul M. Petelin, M.D. The following Board Member abstained: Dona Pardo, R.N., Ph.D. The following Board Member was recused: Douglas D. Lee, M.D.
VOTE: 7-yay, 3-nay, 1-abstain 1-recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-1116A	AMB	JOSE A. PADILLA, M.D.	25251	Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to timely diagnose the transection of the popliteal artery.

William R. Martin, III, M.D. said he knows Dr. Padilla but it will not affect his ability to adjudicate the case.

Dr. Jose Padilla was present with counsel, Mr. Frederick M. Cummings.

Gerald Moczynski, M.D., Medical Consultant summarized the case. This matter came to the Arizona Medical Board from the National Practitioner Databank regarding a malpractice settlement made on behalf of Dr. Padilla. The malpractice claim alleged that Dr. Padilla negatively performed a total knee arthroplasty transecting the popliteal artery leading to amputation of the patient's leg.

The patient was a 73-year-old female with the diagnosis of degenerative arthritis of her knee, diabetes, obesity and hypertension. Dr. Padilla performed a right total knee arthroplasty on September 20th, 2001. The post-op recovery nursing notes state that at 11:10 a.m. the patient's right foot was cool with no pedal pulses palpable. Also noted was the patient was unable to obtain capillary refill. Dr. Padilla was contacted and he ordered a Doppler study. The Doppler study did not identify a pedal pulse, but did identify a popliteal pulse. Dr. Padilla examined the patient and felt he could palpate a faint pulse. He put warm towels on the foot and then returned at 1330 and verified a palpation of a pulse. A nursing note of 1600 noted the pulse improving, but the patient was unable to wiggle her toes. The next day Dr. Padilla again evaluated the patient noting Hemoglobin of 6.2 and a decreased pulse that returned with warming. On the second post operative day Dr. Padilla's associate, noted the patient's right foot to be cold without active dorsa flexion of the toes. Dr. McCormick ordered Doppler studies again that demonstrate there was lack of a pedal pulse and any flow to the popliteal artery. He transferred the patient to a vascular surgeon who noted there was transection of the popliteal artery. The outside medical consultant felt the injury was not below the standard of care, but the failure to recognize the arterial injury in a timely manner was below the standard.

Ram R. Krishna, M.D. led the questioning and noted Dr. Padilla did not document a knee exam on the patient, did not comment on the viability of the foot, and recorded the patient did not have any complaints the day following surgery.

Dr. Padilla said he evaluated the patient and secured a pulse, but failed to document it. He said he was never informed about the patient's pulseless foot the day after surgery. He said he believed the pulse had maintained the evening of the surgery and had improved the next day.

Paul M. Petelin, M.D. said he did not see a problem with the care until the patient sustained a perineal palsy. He said he felt the patient should have been transferred at that point.

Dr. Martin noted the patient’s hemoglobin dropped significantly post-operatively.

Dr. Lee noted it was Dr. Padilla’s testimony he was not notified of the drop in hemoglobin.

Dr. Padilla said he believed he may have transected the patient’s artery, but does not feel he cut it. He said that, in retrospect, an arteriogram was what was indicated and he has and will continue to use the arteriogram since this incident. He also admitted his documentation in the medical record was poor in this case.

Mr. Cummings said he had the case reviewed by a vascular and orthopedic surgeon and there was no finding that the tibia nerve was cut. He also said Dr. Padilla has since changed his documentation and is much more thorough. He said he is also more thorough now in testing his patients.

Dr. Krishna noted there was patient harm in this case of elective surgery. He said the patient’s leg could have been saved if Dr. Padilla would have recognized there was injury to the artery. Dr. Krishna also found the lack of documentation in the medical record to be a significant deviation.

MOTION: Ram R. Krishna, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Krishna said the patient's drop in hemoglobin from 13 to 6 post-operatively should have alerted Dr. Padilla to realize there was significant bleeding and caused him to find the source of the bleeding.

MOTION: Ram R. Krishna, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to timely diagnose the transection of the popliteal artery.
SECONDED: William Martin, M.D.

Dr. Lee spoke against the motion mentioning the mitigating factor that the facility where the patient was treated was at the time a small facility in a rural area with not many services were available.

Dr. Martin said he too acknowledges the mitigating factor, but said there is no documentation there was an attempt to transfer the patient's care and the bottom line of the case was that the patient presented for an elective total knee surgery and ended up with an above the knee amputation.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, M.D. The following Board Member voted against the motion: Douglas D. Lee, M.D.
VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
Motion Passed.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-04-1218A	R.C.	J. KEVIN BELVILLE, M.D.	18584	Advisory Letter for a minor technical error in setting the excimer laser that does not rise to the level of discipline.

J. Kevin Belville, M.D. was present with counsel Mr. Michael Ryan.

Roderic Huber, M.D., Medical Consultant summarized the case. The 60-year-old patient/complainant notified the board in September of 2004 that Dr. Bellville had allegedly performed incorrect Lasix surgery on him and his vision post-procedure was worse than before. This case was reviewed by an outside medical consultant who felt that the data that had been collected by an optometrist was incorrectly entered into the laser control by Dr. Bellville, suggesting a possible transposition of numbers, resulting in an incorrect prescription programmed for the surgery. As a result, the patient had worse astigmatism in his right eye after the procedure. The patient however had a good result in his left eye.

Dr. Belville said the reason for the patient's complaint was not because of his care, but rather as a result of the abrupt closing of the facility he once worked at. He said he since assumed care of the patient and the patient has told him he is thankful for his care and will continue to use him as his physician in the future. Dr. Belville said the patient's outcome was arguably excellent and that he does not believe there was a mistake made with his treatment. He said he spoke to the patient the day of the Board meeting and the patient said he is functioning fully and has had no disability.

Patrick N. Connell, M.D. led the questioning. Dr. Connell questioned Dr. Belville in detail about the data that was collected from the optometrist and compared it to the data entered into the Orbiscan. Dr. Belville said there is a difference in the number of degrees entered into the Orbiscan as compared number of the manifest refraction and that the numbers are not exactly followed as the optometrist recommends in order to obtain the best results. Dr. Connell noted Dr. Belville was not able to recall the specific number of degrees for his treatment goal in operating on this patient. Dr. Beleville said he does not have an independent recollection of this patient and cannot verify there was a transposition in the record, but the outcome of the procedure shows the patient was seeing better overall and he feels that speaks to his accuracy.

Paul M. Petelin, M.D. asked how he would do things differently in the future. Dr. Belleville said he would not join another physician group again. The patient said he would have never filed the complaint if the medical center would not have closed. He said the patient told him his complaint was not about his care.

Patrick N. Connell, M.D. said he must rely on Outside Medical Consultant and testimony heard from the physician in this case. He said the patient's outcome is not concerning in this case, but that the evidence he heard suggests there was an error in the programming of the laser and that he feels this was a technical error.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ram R. Krishna, M.D.
VOTE: 4-yay, 5-nay, 3-abstain/recuse, 0-absent
Motion failed.

MOTION: Paul M. Petelin, Sr., M.D. moved to Dismiss the case.
SECONDED: Lorraine Mackstaller, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D., Becky Jordan, Lorraine Mackstaller, M.D. Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Patrick N. Connell,

M.D., Ronnie R. Cox, Ph.D. , Robert P. Goldfarb, M.D. , Ram R. Krishna, M.D., Douglas D. Lee, M.D. The following Board Member abstained: William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D.
VOTE: 4-yay, 5-nay, 3-abstain 0-recuse, 0-absent
Motion failed.

Sharon B. Megdal, Ph.D. commented that the Board did not have to find unprofessional conduct to issue an Advisory Letter.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for a minor technical error in setting the excimer laser that does not rise to the level of discipline.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D. The following Board Member voted against the action: Paul M. Petelin, M.D. The following Board Members abstained: William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D.
VOTE: 8-yay, 1-nay, 3-abstain 0-recuse, 0-absent
Motion passed.

The meeting was adjourned at 6:51 p.m.

[Seal]

Timothy C. Miller, J.D., Executive Director